

Policy Evaluation of the Effect of Legislation Prohibiting the Payment of Disability Benefits to Individuals Whose Disability is Based on Drug Addiction and Alcoholism

Interim Report

Submitted to:

The Social Security Administration

Contract No. 600-96-27331

Task Order 3, Order No. 0440-97-30026

Project Officer and Task Manager: Kalman Rupp, Ph.D.

Submitted by:

The Lewin Group, Inc.

Principal Investigator: David C. Stapleton, Ph.D.

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and its Subcontractor:

Westat, Inc.

Co-Principal Investigator: Garrett E. Moran, Ph.D.

Robert Ficke

Michelle Harmon, Ph.D.

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The opinions expressed and conclusions drawn in this report are the responsibility of the authors, and do not represent the official views of the Social Security Administration, other agencies, the Lewin Group, or Westat, Inc.

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EXECUTIVE SUMMARY

A. Introduction

Two recent laws substantially restricted (PL 103-296, enacted on August 15, 1994), then essentially eliminated (PL 104-121, enacted on March 29, 1996) eligibility for Social Security Disability Insurance (DI) and Supplemental Security Income (SSI) benefits for persons whose drug addiction and/or alcoholism (DA&A) contributed materially to their disability. In this report, we examine the characteristics of the DA&A beneficiaries on the rolls when PL 104-121 was passed and the law's impact on their eligibility status through December 1997. The empirical findings are based on SSA administrative data, supplemented by referral and monitoring agency (RMA) data for 43 states. We also present findings from a first round of site visits to four states (California, Kentucky, Michigan and Pennsylvania).

B. Beneficiaries Targeted by the 1996 Legislation

PL 104-121 immediately ended allowances to individuals whose DA&A was material to disability, and required SSA to terminate benefits to existing DA&A beneficiaries by January 1, 1997. In June and July 1996, SSA mailed notices to over 209 thousand DA&A beneficiaries, informing them of the pending termination of their benefits and their right to appeal. These beneficiaries comprised approximately 2.6 percent of all DI worker and SSI disabled adult beneficiaries at the time.

The characteristics of the targeted beneficiaries are as follows: most were male (73 percent); a disproportionately large number were black (about 40 percent); very few were non-citizens; 84 percent had been receiving benefits for five or fewer years; and a very large share had a psychiatric impairment. The data also show that the targeted beneficiaries had very limited earnings histories in Social Security covered employment, as well as very low levels of education and training. In addition, a very large share had criminal records.

C. Program Status of Targeted Beneficiaries through December 1997

About 71 thousand of the targeted beneficiaries (34 percent) had retained or re-established eligibility as of December 1997 – approximately half as many as had been anticipated by SSA at the time the legislation was passed. Thus, 138 thousand lost their benefits, but this includes many who would have lost their benefits over the period anyway – including some who were not in payment when the legislation was passed. As a first cut, we estimate that 35 thousand would have lost their benefits in the absence of the new policy, leaving 103 thousand who lost benefits as a direct result of the legislation. We will refine the first-cut estimate later in the project.

Some additional targeted beneficiaries will re-establish eligibility after December 1997. The small number of pending cases in that month and the small number of new claims filed in the last few months of 1997 indicate, however, that the number re-establishing eligibility in the near future will be small -- unless an economic downturn or some other factor precipitates a surge in claims.

Many targeted beneficiaries lost their benefits in January 1997 without filing a reapplication. Due to data limitations, we analyzed the dynamics of the reapplication process only for the SSI cases -- 79 percent of all targeted beneficiaries. About 72 percent of the SSI group reapplied (120 thousand cases). Of these, 49 percent had established eligibility by the end of 1997. While some had predicted that many beneficiaries would take no action until payments actually stopped, the number of SSI beneficiaries filing only after termination of benefits was small as of

the end of 1997. Some of the SSI beneficiaries who were eligible in December 1997 did lose eligibility temporarily, while appeals or new claims were being filed and processed, but most did not have payment interruptions. Only about 9,000 of those who had reapplied (15 percent) had a payment interruption.

D. Characteristics of Targeted Beneficiaries Related to Eligibility in December 1997

Many characteristics observed in the administrative data for the targeted beneficiaries were somewhat predictive of medical eligibility, but none clearly differentiated those who obtained continued eligibility from those who did not. The share who were medically eligible in December 1997 was significantly higher than average for the following groups: those who actually received a payment in March 1996; SSI beneficiaries; female beneficiaries; beneficiaries age 50 and older; white beneficiaries; beneficiaries on the rolls for five or more years; beneficiaries who abused alcohol only; beneficiaries whose primary impairment was not listed as substance abuse; and beneficiaries who achieved initial eligibility only after appeal.

It was widely anticipated that many DA&A beneficiaries would retain eligibility on the basis of a psychiatric co-morbidity. Impairment data for SSI cases confirm this. Of those who were medically eligible in December 1997, 58 percent were eligible on the basis of a psychiatric impairment, including 27 percent in the affective disorder category and 21 percent diagnosed with schizophrenia or some other psychoses. The 42 percent whose disorders for continuing eligibility were non-psychiatric include ten percent in the mental retardation category, eight percent in the musculoskeletal category, and five percent in the circulatory category.

E. Variation across States

We found substantial cross-state variation in DA&A cases per 10,000 persons age 18-64, ranging from 328 in Illinois to 22 in Texas. Factors that likely contributed to this variation include DA&A related decisions in some circuits of the U.S. Courts of Appeals, and cutbacks in state general assistance programs.

We also found substantial cross-state variation in the share of March 1996 DA&A beneficiaries who were medically eligible in December 1997, ranging from a low of 20 percent in Tennessee to a high of 51 percent in New York. We do not have empirical evidence on the cause of this variation at present; it does not appear to be related to cross-state variation in prevalence.

F. Case Study Findings

The case studies were designed to capture a broad range of views of both government and non-government informants on the implementation of DA&A policy and the likely impacts of the policy on the organizations providing support and services to substance abusers. To a limited extent, we also learned about the impacts on the lives of the beneficiaries themselves. Because only four states were studied, substantial caution must be exercised against inappropriately generalizing the findings.

One of the principal focuses of the case studies was the nation-wide system of RMAs, established by the 1994 legislation. This system was barely operational before the 1996 legislation eliminated it. Establishing these agencies was a complex undertaking, and there simply was too little time between their development and their termination to provide a good test of their utility. It appears that RMA activity did result in a substantial number of non-compliant beneficiaries losing eligibility and that some number of beneficiaries did benefit from the

mandated treatment participation. Critics reported, however, that the establishment of RMAs was an expensive undertaking that, in the long run, may or may not have proved cost effective.

The case study findings suggest that many individuals and organizations, in particular SSA field office staff and organizational representative payees (ORPs), were genuinely concerned about the welfare of the affected beneficiaries. All the field offices we visited undertook significant outreach activities to inform DA&A cases of their impending terminations, their right to appeal, and appeal procedures. These activities varied, however, in type and level of effort. We heard anecdotal reports of the success of these efforts. We found evidence that at least some ORPs actively assisted their clients in the appeals process.

We were impressed with the knowledge and professionalism of the DDS staff members we interviewed. The number of SSI recipients whose appeals were initially denied and who chose the option of a face-to-face reconsideration required that state DDSs train many hearings officers. While we heard claims that the many who elected face-to-face interviews were more likely to receive allowances, we have not yet been able to substantiate them. One criticism of the appeals process offered by advocates was that consultative examinations were too brief and perfunctory. Both SSA and state DDS staff disputed this claim. All agreed, however, that the scarcity of well-developed historical medical records made decisions difficult.

We did not talk to beneficiaries themselves. We did, however, encounter widespread observations that the incomes of terminated beneficiaries had dropped substantially, and that participation in treatment declined substantially. In the two states we visited with general assistance programs, we heard reports that substantial numbers obtained such assistance. We also heard reports of increased homelessness, from three ORP interviewees. We heard very few reports of former beneficiaries returning to employment.

G. Overview of the Report

In **Chapter II** we present the quantitative analysis of the targeted beneficiaries. In **Chapter III**, we present the findings from the first round of case study site visits. In **Chapter IV**, we discuss the implications of the findings for the additional work planned for this project. Technical details and detailed tables appear in the **Appendix**.

I. INTRODUCTION

A. Overview of the Project

Two recent laws substantially restricted (Section 201 of PL 103-296, enacted on August 15, 1994), then essentially eliminated (Section 105 of PL 104-121, enacted on March 29, 1996) eligibility for Social Security Disability Insurance (DI) and Supplemental Security Income (SSI) benefits for those whose drug addiction and alcoholism (DA&A) contributed materially to their disability. This report is the second major report in a project to evaluate the net effect of this legislation on program caseloads and costs. The project is one of three policy evaluation studies of the effects of recent welfare reform legislation on Social Security Administration (SSA) programs.¹ More specifically, this project will:

- Provide quantitative estimates of the effects of the legislation on those who were beneficiaries in the DA&A category prior to enactment, including the net effect on the caseload and program cost;
- Provide quantitative estimates of the net reduction in future allowances resulting from the legislation; and
- Provide a quantitative and qualitative assessment of the impacts on the lives of those affected -- including effects on family income, support from other public sources, living arrangements, drug and alcohol treatment, utilization of health services, criminal activity-- and on other public and private sources of income and in-kind support.

In a previous report, we presented substantial background material and described our preliminary analysis plans (Lewin 1997b). In a second report, we presented an assessment of non-SSA survey and administrative data that might be used to supplement the quantitative analysis of SSA data that is planned for later in the project (Lewin, 1998).² Where appropriate, we have incorporated material from these earlier reports in this report.

In this report we present a preliminary analysis of the characteristics and program status of the existing program beneficiaries who were the target of the 1996 legislation – those on the rolls and in the DA&A category in March 1996. We also present findings from a first round of site visits to case study states. Remaining major project activities and deliverables, scheduled for 1998, include:

¹ The other two are evaluating the effects of: 1) changes in SSI child eligibility, and 2) changes in non-SSA programs, especially the replacement of the Aid to Families with Dependent Children program with Transitional Assistance for Needy Families.

² The data assessed are the Center for Substance Abuse Treatment's longitudinal survey of SSI DA&A recipients, the Pennsylvania Longitudinal Data Base, which are administrative data covering all users of public mental health services in Philadelphia from 1986 on, and the Referral and Monitoring Agency (RMA) data from Maximus, Inc., collected by Maximus when Maximus served as the RMA contractor for DA&A recipients in 43 states.

- A final analysis plan;
- A Technical Support Group meeting to review interim findings and the analysis plan;
- A second round of site visits and case study reports;
- Analysis of net impacts on SSA caseloads and benefit payments, using SSA administrative data; and
- Analysis of net impacts on the lives of beneficiaries, using non-SSA data that may be linked to SSA data.

B. History of Legislation Affecting DA&A Beneficiaries

The first specific provisions for drug addicts or alcoholics in either the DI or SSI programs appeared in the *Social Security Act Amendments of 1972 (PL 92-603)*.³ The 1972 Amendments required that a SSI beneficiary whose drug addiction and/or alcoholism were material to his or her disability receive payments through a representative payee and participate in treatment, if the appropriate treatment was available. The Amendments also required that SSA provide for the monitoring and testing of these individuals. The 1972 Amendments imposed no restrictions on the payment of SSI benefits to individuals with a drug addiction or alcoholism, but whose addiction was not material to the finding of disability. Furthermore, the Amendments imposed no restrictions on DI benefits to drug addicts or alcoholics, even if their addiction was material to the finding of disability.

In response to concern about the rising number and monitoring of addicts receiving disability benefits, Congress included several provisions for DA&A beneficiaries in the *Social Security Independence and Program Improvements Act of 1994 (PL 103-296)*. Section 201 of PL 103-296:

- Placed a three-year time limit on both SSI and DI benefits to persons whose drug addiction or alcoholism was material to their disability;
- Extended treatment and monitoring requirements to DI recipients whose DA&A status was material to their disability;
- Allowed for the temporary or permanent suspension of benefits to recipients who failed to comply with treatment requirements;
- Required recipients classified as substance abusers and found incapable of managing their benefits to receive their benefits through representative payees;

³Prior to the 1972 Amendments, Title XVI of the Social Security Act provided for grants to States for aid to the aged, blind, and disabled. The 1972 amendments amended Title XVI in its entirety under the Title “Supplemental Security Income for the Aged, Blind, and Disabled.” The new Title XVI became effective on January 1, 1974.

- Tightened the criteria for representative payees;
- Encouraged organizations and agencies to act as representative payees; and
- Ordered SSA to establish referral and monitoring agreements in all States.

PL 103-296 was the first law to place any restrictions on the receipt of DI benefits for drug addiction or alcoholism. DI beneficiaries who were receiving benefits at the time of enactment were initially designated DA&A solely on the basis of whether they had a diagnostic coding of drug addiction and/or alcoholism and not whether this diagnosis was material to the finding of disability. SSA only evaluated the materiality of a diagnostic coding of drug addiction and/or alcoholism for new DI-only allowances or if an existing DI-only beneficiary appealed his or her change in program status. If the addiction was found not to be material on appeal, the beneficiary was no longer subject to the provisions of PL 103-296.

Despite the implementation of the DA&A provisions passed in 1994, the DA&A caseload continued to grow. Many in Congress came to see the DA&A program as “inappropriately diverting scarce Federal resources from severely disabled individuals” and “providing a perverse incentive, contrary to the long-term interest of alcoholics and addicts, by providing them with cash payments so long as they do not work” (Committee on Finance, 1995). This largely bipartisan position culminated in legislation that became part of the *Contract with America Advancement Act of 1996*, which was enacted as PL 104-121 on March 29, 1996.

Section 105 of PL 104-121 eliminates eligibility for DI and SSI benefits as well as Medicare and Medicaid coverage to individuals whose drug addiction or alcoholism is a contributing factor material to their disability. Beginning on the day of enactment, SSA ceased to award SSI and DI benefits to persons whose drug addiction or alcoholism was material to their disability. The law also ended the eligibility of SSI and DI DA&A beneficiaries on the rolls as of March 29, 1996 on January 1, 1997, unless they successfully appealed the termination. SSA granted all DA&A beneficiaries the standard 60 days after they received notice of their eligibility termination to submit an appeal. Beneficiaries scheduled to have their benefits terminated could appeal on the basis that:

- Their SSA record was incorrectly coded DA&A and that their benefits were not based on DA&A;
- They were disabled without considering drug addiction or alcoholism and desired a new medical determination;
- They were age 65 or turned 65 before January 2, 1997, and were, therefore, eligible for SSI based on age; or,
- They were age 62 before January 2, 1997, and, therefore, eligible for Social Security retirement benefits.

Individuals who appealed their benefit terminations on or before July 29, and who had received no medical determination prior to December 31, continued to receive benefits while they waited for this initial decision. If the medical determination found no disability in such a case, SSA terminated benefits immediately. If, however, a beneficiary was a SSI-only beneficiary and

covered under the Goldberg-Kelly provisions, the beneficiary continued to receive benefits through the reconsideration level.⁴

The current statute continues to allow individuals with a drug addiction or alcoholism who have another disabling condition(s) (e.g., AIDS, heart disease, schizophrenia) to qualify for benefits based on that disabling condition. However, the law requires that such individuals be referred to treatment and, if found incapable of managing their benefits, receive their benefits through a representative payee. In addition, PL 104-121 appropriated \$50 million for each of FYs 1997 and 1998 for activities relating to the treatment of drug and alcohol abuse, under the Public Health Service Act.

C. Overview of the Report

In **Chapter II** of the report, we present an analysis of the SSI and DI beneficiaries who were in DA&A status at the time that PL 104-121 was passed, including both an assessment of their characteristics and their eligibility status through June 1997. This provides first-cut estimates of the impact on existing beneficiaries. These estimates will be revised later in the project, and we also plan to examine impacts on allowances.

In **Chapter III** we present the findings from the first round of site visits to four states, California, Kentucky, Michigan, and Pennsylvania. These were conducted in July and August of 1997. A second round is planned for 1998.

In **Chapter IV** we summarize the findings and discuss their implications for policy and for the additional work planned for this project.

⁴ The Goldberg-Kelly provisions require that a beneficiary file a timely appeal and receive a payment in the month prior to termination -- in this case, December 1996. The Goldberg-Kelly provisions also allow for the continuation of SSI payments if good cause is found for a late filing of an appeal.

II. FINDINGS FROM ANALYSIS OF ADMINISTRATIVE DATA

A. Introduction

1. Purpose of the Analysis

The approximately two hundred thousand individuals in the March 1996 Cohort of DA&A beneficiaries were essentially the last SSI and DI beneficiaries eligible to receive benefits with drug or alcohol abuse being material to all qualifying impairments. For most, benefit eligibility continued through December 1996, after which payment was terminated unless they had successfully appealed their DA&A status, had turned 62 (DI) or 65 (SSI), or, under certain conditions, were in the appeals process.

In this analysis, we utilize SSA administrative data to describe what happened to this cohort of beneficiaries after the implementation of the DA&A policies. We also examine referral and monitoring agency (RMA) data compiled by Maximus, Inc. to supplement the findings from the SSA administrative data.

The most readily observable outcomes of the termination of benefits are changes in program status for beneficiaries in this group. Hence, analysis of their characteristics and their participation changes provide “first-cut” information about these DA&A beneficiaries and the impacts of the policy changes. This “first cut” analysis both anticipates later findings and serves to inform the remainder of the research effort.

The specific objectives of the analysis of the March 1996 DA&A Cohort are:

- To describe the beneficiaries that were targeted by the legislation;
- To measure gross changes in those outcomes that are captured in SSA administrative data including program payments and eligibility, and to examine how gross outcome changes vary by certain beneficiary characteristics and state;
- To produce information that will be helpful in the development of the caseload and benefit models; and
- To produce information that will be helpful in assessing the initial case study findings and in planning and conducting the follow-up site visits.

2. Organization of the Chapter

The remainder of this chapter is organized as follows:

- In **Section II.B**, we provide a brief summary of the data and methods used to conduct the analysis. We recommend that all readers review this section because several features of the

data and the programs affect the way we present the findings and the terminology we use. A more detailed summary appears in the **Appendix**;

- In **Section II.C**, we discuss the March 1996 status and characteristics of beneficiaries who were sent notices;
- In **Section II.D**, we present findings on changes in the status of DA&A beneficiaries from March 1996 through December 1997; and
- In **Section II.F**, we present findings on cross-state variation in the numbers of DA&A beneficiaries in March 1996 and in the percent who were deemed medically eligible prior to December 31, 1997.

B. Data and Methods

1. Description of the Data

The statistics presented in this report are based on extracts from five SSA databases: the DA&A Universe File; the SSI DA&A 100% Supplemental Security Record March 1996 Extract (100% SSR Extract); the SSI 10% Monthly DA&A Tracking File; the 100% DA&A Master Beneficiary Record Extract (100% MBR Extract); and The Master Earnings File (MEF). The findings, and the way they are presented, reflect the structure of these files. We also report findings from an analysis of referral and monitoring agency (RMA) data in 43 states, provided by Maximus, Inc., the contractor for these services in those states.

The Universe File was created by the SSA's Office of Disability (OD) in May and June 1996, and identifies all SSI and DI beneficiaries who were receiving disability benefits on the basis of drug addiction or alcoholism in that two-month period -- the 209,374 individuals who received benefit termination notices in June and July 1996. We used SSNs from this file to find data on these cases in other files.

The principle source of data for SSI beneficiaries, including concurrent beneficiaries (those also receiving DI), is different -- and in many ways richer -- than that for DI-only beneficiaries. As a result, we present more information for SSI cases than we do for DI cases. Most SSI data come from the SSR, from which we obtained both the 100% SSR Extract and the 10% Tracking File. Most DI-only data come from the MBR. A key difference between the SSR and MBR is that the data in the former are generally not overwritten when a beneficiary's circumstances change, while data in the latter often are. Other differences in the data we present for SSI and DI-only beneficiaries reflect program differences.

The MEF was accessed only to obtain Social Security earnings histories for beneficiaries in both programs. In order to satisfy special IRS confidentiality restrictions that apply to the MEF, SSA staff actually performed the analysis using programs that were written by Lewin Group staff.

Because the legislation was passed on March 29, 1996 and DA&A allowances were ended immediately, we wanted to take a "snapshot" of DA&A beneficiaries on the rolls in March 1996. The snapshot we present, as well as many subsequent program status statistics, is based on only

95.0 percent of the 209,374 beneficiaries who were sent notices – 198,855 cases. The other five percent are excluded because either their program classification (DI vs. SSI) or their DA&A designation changed from March 1996 to May-June 1996. These changes made it problematic to match Universe File records for these individuals to other program records.

The 10% SSI DA&A Tracking File was constructed from large monthly 10% SSR extracts so that we could follow the program status of a random sample of SSI DA&A cases monthly from March 1996 through December 1997. As discussed further below, program status may be defined in many different ways, and the various measures often diverge substantially when a policy changes. Monthly data for the DI-only cases is more limited, especially before January 1997.

The analysis of the Maximus data is presented in full in Lewin (1998). The data pertain to the characteristics of the beneficiary at the time the beneficiary was enrolled in the RMA. The time frame for the initial enrollment interviews was February 1994 to October 1996 with the majority of these interviews conducted in 1996. The Maximus data provide additional descriptive information on the status of DA&A beneficiaries not available in the SSA administrative data.

The Maximus data are not representative of all DA&A beneficiaries because they only include cases for 43 states. Also, the data are not necessarily representative of all DA&A beneficiaries in these states because not all beneficiaries in these states were enrolled in the RMA. The majority were enrolled, however, and our earlier analysis showed that enrollee characteristics matched those of all DA&A beneficiaries in the 43 states quite well. In comparison to DA&A beneficiaries from all states, those in the Maximus states are somewhat more likely to be SSI-only. In addition, the percentage of beneficiaries that are white is larger in the Maximus cases than in the total DA&A population, reflecting racial differences in beneficiary characteristics across the Maximus and non-Maximus states.

2. Program Classifications

In this report we use a somewhat innovative classification scheme for program participation (DI and/or SSI). Beneficiaries are classified into two mutually exclusive groups, with two mutually exclusive subgroups each, based on their program status in May/June 1996:

- **SSI Beneficiaries**
 - **SSI-only** -- individuals who were eligible for SSI benefits, but not for DI benefits.
 - **Concurrent** -- individuals who were concurrently eligible for both SSI and DI benefits.
- **DI-only Beneficiaries**
 - **Never SSI** -- individuals who were eligible for DI benefits and who had never been eligible for SSI benefits.

- **Serial** -- individuals who were eligible for DI benefits only and who had lost eligibility for SSI benefits because of excess income.⁵

3. Program Status Definitions

As mentioned previously, the program status of a recipient can be defined in several ways, and “participation” in DI or SSI at a point in time may depend on which definition is used, especially during transition periods. Several definitions are used in this report, in part to determine the relationship between them, and in part because of availability. They are:

- **Payment Status** – a recipient’s payment status (i.e., eligibility for payment) in any given month is determined in the preceding month. SSA declares an individual who meets all the medical and non-medical criteria of either the SSI or DI program as being in “current pay” status for that program. Individuals who do not meet one or more criteria for a program are placed in non-pay, suspended, or terminated status depending on the nature and length of their failure to meet eligibility criteria.
- **Paid**– a recipient is classified as “paid” if SSA issued the individual a payment in a given month. The paid classification includes people who actually received payment as well as those who did not receive payment because the check was returned or because of some administrative reason such as a forced stop payment. The paid category generally includes all individuals whose eligibility status is “current pay” as well as people who are receiving retroactive payments for earlier eligibility and/or SSI continuation payments to which they were entitled under the legislation. Because eligibility for payment is determined in the month prior to payment, it is possible, for example, for a person found in March to be eligible for payment in April (i.e., in current pay status), but not actually receive the payment in April for a number of reasons including incarceration, non-compliance with SSA program regulations, and death.

Retroactive payments are often made when a new award is made. Prior to 1994, these retroactive payments usually came in the form of lump sum payments. However, PL 103-296, required the gradual payment of retroactive benefits to DA&A recipients. As a result, it is possible for an individual to be currently ineligible for payment (i.e., in a non-pay, suspended, or terminated status) yet still receive benefit payments for an extended period. In the months leading up to January 1997, as many as four percent of all SSI DA&A cases received payments despite being currently ineligible.

- **Medical and Non-medical Eligibility** – both programs have both medical and non-medical criteria for eligibility. The medical criteria are the same, but the non-medical criteria differ. The most up-to-date information on the status of former DA&A recipients is on their medical eligibility. Presumably those former DI recipients who have been found to be medically eligible upon reapplication or new application continue to meet the non-medical eligibility for DI, which is based on past earnings histories. Former SSI recipients who have been

⁵ This often happens after the five-month DI waiting period, but can also happen if the SSI recipient obtains disability insured status through accumulation of quarters of Social Security employment or if the recipient obtains increased unearned income from another source.

found to be medically eligible do not necessarily meet the non-medical criteria, although we suspect that the vast majority do.

4. Reapplications vs. New Applications

Former DA&A recipients could seek continued benefits through three routes: by a timely appeal of their scheduled termination filed prior to July 29, 1996, by a late appeal filed after July 29, 1996 but before January 1, 1997, or by filing a new application at any time after termination. Following SSA practice, we refer collectively to both timely and late appeals as “reapplications.” Note that the sum of “reapplications” and “new applications” exceeds the number of former recipients who have sought to retain or re-establish their benefits as some that unsuccessfully pursued the first route have subsequently pursued the second.⁶

C. Beneficiaries Targeted by the 1996 Legislation

1. Program Status of Targeted Beneficiaries in March 1996

Section 105 of PL 104-121 was enacted on March 29, 1997, and immediately ended allowances for those whose DA&A was material to disability. It also required SSA to terminate benefits to existing DA&A beneficiaries by January 1, 1997, after giving them an opportunity to appeal their DA&A designation. Identifying and notifying beneficiaries whose substance abuse was material to disability was itself an important, and challenging, task. Casting too broad a net could create an unnecessarily large administrative burden on the agency for processing appeals and unnecessarily threaten beneficiaries for whom substance abuse was not material to disability; many such beneficiaries are extremely vulnerable, and some may be incapable of filing an appeal without substantial help. Casting too narrow a net, however, could result in retention of benefits by significant numbers whose substance abuse was material to disability.

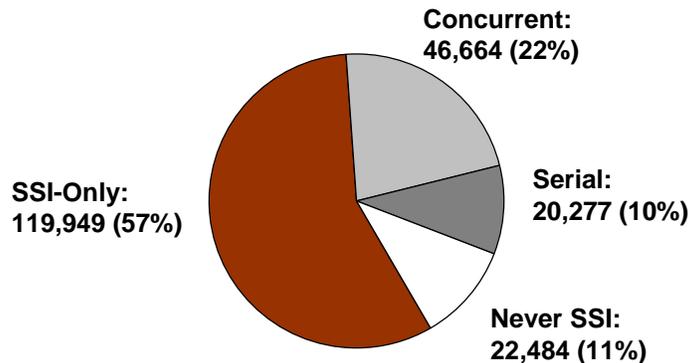
Our analysis found that the vast majority of recipients who were sent notices had been designated as DA&A before the legislation was passed, and were, in fact, active SSI or DI beneficiaries when the legislation was passed. The 209 thousand beneficiaries who were sent notices were designated as DA&A beneficiaries in SSA administrative records in either April or May of 1996. We found that all but 2,310 were both on the DI and/or SSI rolls and already designated as DA&A beneficiaries in March 1996. The relatively small number who do not appear to have been beneficiaries in March who were not designated as DA&A until April or May.

A large majority (80 percent) of those sent notices were SSI beneficiaries, of whom the majority were SSI-only beneficiaries (**Exhibit II.1**). A total of 43 percent were DI beneficiaries,

⁶ SSA guaranteed continued benefits beyond December 31, 1996 to all DI and SSI beneficiaries filing a timely appeal if they had not yet received an initial medical decision, and the Goldberg/Kelly provisions permitted continuation of payments to SSI recipients filing timely appeals through the reconsideration level. For this reason, it would have been useful to distinguish between “timely” and “late” appeals, but this proved problematic with the administrative data we had available. Thus, while we present data on SSI recipients who continued to receive payment despite loss of eligibility after January 1, 1997, we do not analyze the reason for the continued payment.

including 22 percent who were concurrently receiving SSI and another 10 percent who had received SSI in the past (Serial). Only 11 percent of cases were DI beneficiaries who had never been SSI beneficiaries.

Exhibit II.1
May/June 1996 Program Status of Target Beneficiaries



Source: Lewin Group analysis of SSA's DA&A Universe File, SSR, and MBR. See Exhibit App.II.2.

A very large share of the cases we analyzed were, in fact, receiving benefits in March 1996 -- 94 percent overall (**Exhibit II.2**).⁷ Many of those whose payments were suspended were likely "active" beneficiaries in that they may have returned to payment status in the absence of the policy change. In fact, about 17 percent of them were determined to be medically eligible by the end of December 1997, a rate only slightly less than half that for individuals who received benefits in March 1996. Furthermore, over half of the 14.4 percent of SSI recipients who did not receive an SSI payment in March did receive a DI payment (8.3 percent of SSI cases). Presumably, technical (non-medical) reasons made these beneficiaries ineligible for an SSI payment. A very small number (44) were deceased.

Exhibit II.2
Receipt of Payment in March 1996 by Target Beneficiaries

	Cases Analyzed	No Payment	Payment			
			Total	SSI Only	DI Only	Both
Total	198,855	6.0%	94.0%	53.8%	24.4%	15.8%
DI-only	42,729	5.5%	94.5%	0.0%	94.5%	0.0%
Never SSI	22,453	4.5%	95.5%	0.0%	95.5%	0.0%
Serial	20,273	6.6%	93.4%	0.0%	93.4%	0.0%
SSI	156,126	6.1%	93.9%	68.5%	5.4%	20.0%
SSI-only	114,649	7.5%	92.5%	92.5%	0.0%	0.0%
Concurrent	41,477	2.4%	97.6%	2.3%	20.2%	75.2%

Source: Lewin Group analysis of SSA's DA&A Universe File, SSR, and MBR. See Exhibit App.I.2.

⁷ This number includes DI beneficiaries who may have received benefits for March 1996 retroactively at a later date.

Based on the administrative data alone, it appears that SSA did target essentially all beneficiaries who were likely to meet the “DA&A material” criteria, and successfully avoided sending unnecessary notices to beneficiaries who were not. This does not mean that DA&A truly was material to all beneficiaries who were sent notices because many beneficiaries who were able to obtain continued benefits (Section II.E). Because time had passed since they were designated DA&A, the materiality of their DA&A may have changed, and some cases may have simply been misclassified in the first place.⁸

2. Characteristics of DA&A Beneficiaries in March 1996

SSA has previously analyzed the characteristics of SSI DA&A beneficiaries, most recently in December 1995 (Barber, 1996). We replicated this analysis for March 1996, but also extended it to examine more information on earnings and participation histories and to cover DI-only beneficiaries. Not surprisingly, the characteristics observed for the SSI cases in both December 1995 and March 1996 changed very little.⁹

a) Demographics¹⁰

The targeted SSI beneficiaries were:

- Predominantly male (73 percent, compared to 42 percent of all disabled adult SSI recipients);
- Concentrated in the 30-49 age range (69 percent compared to 39 percent of all disabled adult SSI beneficiaries and 61 percent of the population age 18 - 64). Female beneficiaries were, on average, about three years younger than male beneficiaries;
- Disproportionately black (37 percent compared to 31 percent of all disabled SSI beneficiaries and 12.3 percent of the population age 18 - 64);¹¹ and
- Almost all citizens (98.7 percent).

We have less information about DI-only cases because of differences in administrative records for DI and SSI. In comparison to the SSI cases, the DI-only cases were:

- Even more likely to be male (87 percent);

⁸ The latter statement is especially true for DI-only cases allowed before the 1994 legislation. We understand that designations for such cases were made retrospectively, based on limited data from administrative records. Based on the duration data for DI-only cases, it appears that about 60 percent of the DI-only cases sent notices were allowed before the 1994 legislation (approximately 25,000 individuals). About half of these, however, received an SSI benefit and were likely to have been designated DA&A through the usual procedure applied to SSI cases at that time, so the number whose designation was determined retrospectively using administrative data is likely 12 to 13 thousand or so – about six percent of the total receiving notices.

⁹ See Exhibits App.I.2 and App.I.3.

¹⁰ Comparison statistics are from December 1995 for SSI and from 1996 for the general population. These statistics were respectively obtained from SSA(1996) and U.S. Bureau of the Census (1997).

¹¹ The percentage of SSI beneficiaries aged 18 to 64 who are black is unavailable. The figure reported here includes both child and adult SSI disabled beneficiaries.

- Somewhat older, but also highly concentrated in the 30-49 age range (64 percent); and
- Less likely to be black (27 percent), although still disproportionately black in comparison to the general population.

Citizenship data were not available for DI-only cases.

Analysis of Maximus RMA data presented in Lewin (1998) suggests that although a substantial number of DA&A beneficiaries lived with children under the age of 18, the large majority of DA&A beneficiaries did not. Of those DA&A beneficiaries interviewed by Maximus, only 15.2 percent had children under the age of 18 living with them.¹² It seems likely that a substantial number of beneficiaries who were living with children could have been eligible for AFDC if they had not been SSI or DI beneficiaries. Women were nearly twice as likely as men to have a child living with them (23.6 vs. 11.9 percent), and 2.3 percent of female cases interviewed by Maximus were currently pregnant at the time.

b) Earnings, Employment, and Program Participation Histories

We looked in some detail at the Social Security earnings histories of the target beneficiaries because an important objective of the new policy is to encourage this population to take responsibility for their own support, through employment in legitimate jobs. The data show that these beneficiaries did, in fact, have very limited Social Security earnings histories – confirming the concerns of policy makers about their past behavior, and also suggesting that changing their patterns of behavior will be a major challenge.¹³ This is evident from the fact that, as discussed previously, such a high percentage were SSI recipients, or had been at some point in the past. In addition, we found that (**Exhibit II.3**):

- 46 percent had Social Security earnings in less than 60 percent of their adult years prior to program participation -- 28.5 percent in less than 40 percent of those years;
- 89 percent had earnings below the (single-person) poverty line in the calendar year prior to program participation. The percent with earnings below poverty was only slightly lower two and three years prior to participation; and
- 81 percent had no Social Security earnings in 1995, and only 2.8 percent had 1995 earnings above the poverty line.

As to be expected, Social Security earnings histories are most limited for the SSI-only cases, and least limited for the Never SSI cases. Even for the latter, however, Social Security earnings are low in the years just prior to participation; in the third calendar year before allowance, 16.6 percent had no earnings and only 43.4 percent had earnings above the poverty line. We also found that female beneficiaries had more limited Social Security earnings than male beneficiaries had; one result of this is that a larger share were receiving SSI.

¹² We do not know how many cases had children under 18 who were not living with them.

¹³ The findings regarding the limited work and earnings histories of the target population are consistent with earlier research, particularly Lewin (1997a) on the employment and income of people with substance abuse disorders.

Exhibit II.3
Social Security Earnings Histories of March 1996 DA&A Beneficiaries

Characteristics	DI –only			SSI			Total
	Total	Never SSI	Serial	Total	Only	Con-current	
Percent of Adult Years Before Program Entry with Social Security Earnings							
Less than 40%	12.2	2.3	23.2	33.0	42.8	5.9	28.5
Less than 60%	15.1	5.3	26.0	54.2	68.4	14.8	45.8
Percent with Social Security Earnings below Individual Poverty Line							
In 1995	96.3	96.0	96.7	98.7	99.0	98.0	98.2
Last full year before program entry	70.1	63.8	77.1	94.2	98.2	82.9	89.0
2 nd full year before program entry	62.2	54.3	70.8	92.4	97.6	78.3	85.9
3 rd full year before program entry	56.6	48.3	65.8	91.5	97.3	75.1	84.0

Source: Lewin Group analysis of SSA's DA&A Universe File, SSR, and MBR. See Exhibit App.II.2.

The fact that over two-thirds of the targeted beneficiaries were between the ages of 30 and 49 – normally prime working years when an employment “habit” is well established – makes their limited Social Security earnings histories and low levels of education all the more striking.

We also found that 84 percent of targeted beneficiaries had been receiving benefits for five or fewer years, reflecting the surge in awards in the DA&A category that began in the late 1980s. Presumably these beneficiaries had other sources of support besides Social Security earnings before they became beneficiaries. Some beneficiaries may return to these sources upon benefit termination -- family and friends, other sources of cash benefits, and earnings from work not covered by Social Security, including illegal activities.

Findings from the Maximus RMA data on the educational, occupational, and criminal background of DA&A beneficiaries provide further evidence that most DA&A beneficiaries had limited attachment to the labor force prior to the onset of disability and are ill-equipped to enter it now. Of the nearly 83,000 DA&A beneficiaries included in the Maximus data:

- Nearly half had less than twelve years of formal education, while an additional 33 percent had only twelve years of formal education;
- 64 percent had no technical training and another 19 percent had twelve months or less of technical training;
- Less than 10 percent classified their last or usual occupation as administrative, clerical, or business oriented, while 40 percent classified themselves as skilled or semi-skilled manual workers. An additional 34 percent classified their last or usual occupation as unskilled or unemployed; and
- A large majority (84 percent) had been charged with a criminal offense. Male Maximus cases were more likely to have had a criminal charge than female cases (87.3 vs. 76.9 percent) and were also more likely to have been charged with a drug-related offense or a violent crime.

The findings from the Maximus data suggest that many DA&A beneficiaries whose benefits were terminated are likely to have difficulty finding and keeping gainful employment, let alone supporting themselves financially, without assistance from public or private sources. Furthermore, the historically high rates of criminal behavior among DA&A beneficiaries suggests that many former beneficiaries, may engage in illegal activities to support themselves, especially if faced with employment difficulties.

The 1994 legislation sought to ensure that all DA&A cases had representative payees, and encouraged use of organizational representative payees. It appears that the first of these objectives was essentially attained, but the second was not. Almost all (99.2 percent) of the targeted SSI beneficiaries had representative payees in March 1996. Over 50 percent of DA&A beneficiaries had a representative payee who was a member of their immediate or extended family. This finding lends support to the hypothesis that many DA&A beneficiaries had strong economic ties to their families and would likely turn to them for support upon termination of benefits.

Over half (53 percent) of SSI DA&A beneficiaries in March 1996 were awarded SSI eligibility at their initial determination. In comparison, over 81 percent of all SSI blind and disabled recipients eligible in December 1995 received an initial award.¹⁴ About 32 percent did not obtain eligibility until the hearing (ALJ) level. This rate was over three times that for all SSI blind and disabled recipients.¹⁵ An additional 0.4 percent received an award from an Appeals Council. The large number of cases allowed at the hearing level or above suggests that there was substantial discrepancy in how individual state disability determination services evaluated DA&A cases. It also suggests that a large share of the SSI DA&A cohort was made up of highly motivated individuals.

c) Impairment

The impairment data we analyzed for March 1996 are for SSI cases only, and indicate the impairment on which their eligibility was based at that time.¹⁶ This information was missing for 18.6 percent of SSI cases, mostly in cases allowed at the appellate level.

Almost 75 percent of the SSI cases were classified in a psychiatric category, including 63.8 percent in the substance abuse category; the next largest share was in the affective disorder category (4.4 percent). The only non-psychiatric category with a substantial share was mental retardation (3.0 percent). Very few were listed in the cirrhosis of the liver or liver disease category (0.3 percent), impairments often associated with severe alcohol abuse.

Data on addiction type were available for essentially all SSI cases, reflecting the fact that a DA&A determination had been made at the time of allowance in most cases. The majority were addicted to alcohol only (52.3 percent). An additional 29.9 percent were addicted to both alcohol and drugs, and the remainder (17.7 percent) were addicted to drugs alone. Addiction data are

¹⁴ Barber (1996).

¹⁵ Barber (1996).

¹⁶ This may differ from the impairment that was the basis for their original allowance.

available for only about 54 percent of DI-only cases, reflecting the fact that many were classified as DA&A on the basis of a retrospective examination of administrative data. For cases with data, alcoholism was more prevalent than for SSI cases – 68.2 percent were classified as alcohol only, and an additional 12.1 percent as both. We also found that female beneficiaries were more likely to be addicted to drugs than male beneficiaries (51.4 percent vs. 40.0 percent). We also found that beneficiaries in the alcohol only classification were disproportionately white, and were about three years older, on average, than other DA&A beneficiaries.

The Maximus data contain sensitive diagnostic assessments of beneficiaries. As part of these assessments, a determination of substance abuse addiction and treatment requirements was made by the case manager. The case managers' addiction scores are divided into categories that range from "no problem-no treatment necessary" to "extreme problem-treatment necessary."

Based on the case manager assessments, most beneficiaries (60.8 percent) had a substance abuse problem that was sufficiently severe to require treatment at the time they were observed. Thus, if benefit loss reduces access to treatment, as some have feared, the number adversely affected may be substantial. The case managers also found that 6.7 percent of all cases did not have an addiction, another 10.2 percent had either "no problem" or "no real problem," and another 18.2 percent had problems that may not have required treatment. It may be that successful treatment in the past accounts for the 39.2 percent of cases that apparently did not require treatment, but another explanation is that some were misclassified as DA&A. Evidence from the case studies indicates that this sometimes occurred.¹⁷ The RMAs provided a means for many substance abusers to obtain access to appropriate treatment. Based on research suggesting that only about one in eight substance abusers get the treatment they require, it appears likely that many former DA&A beneficiaries will not seek or be able to obtain appropriate treatment.¹⁸

D. Program Status of Targeted Beneficiaries through December 1997

1. Terminations as of December 1997

Of the 209 thousand targeted beneficiaries who were sent notices in June and July of 1996, 34 percent, or approximately 71 thousand beneficiaries, had been found medically eligible on reapplication or as a result of a new claim as of December 31, 1997. This is slightly less than half the number that SSA had expected would remain on, or eventually return to, the rolls under another disabling condition. Recent trends in the filing and adjudication of reapplications make it seem very unlikely that the number of returning beneficiaries will make up the difference between the number of beneficiaries medically eligible in December 1997 and the pre-

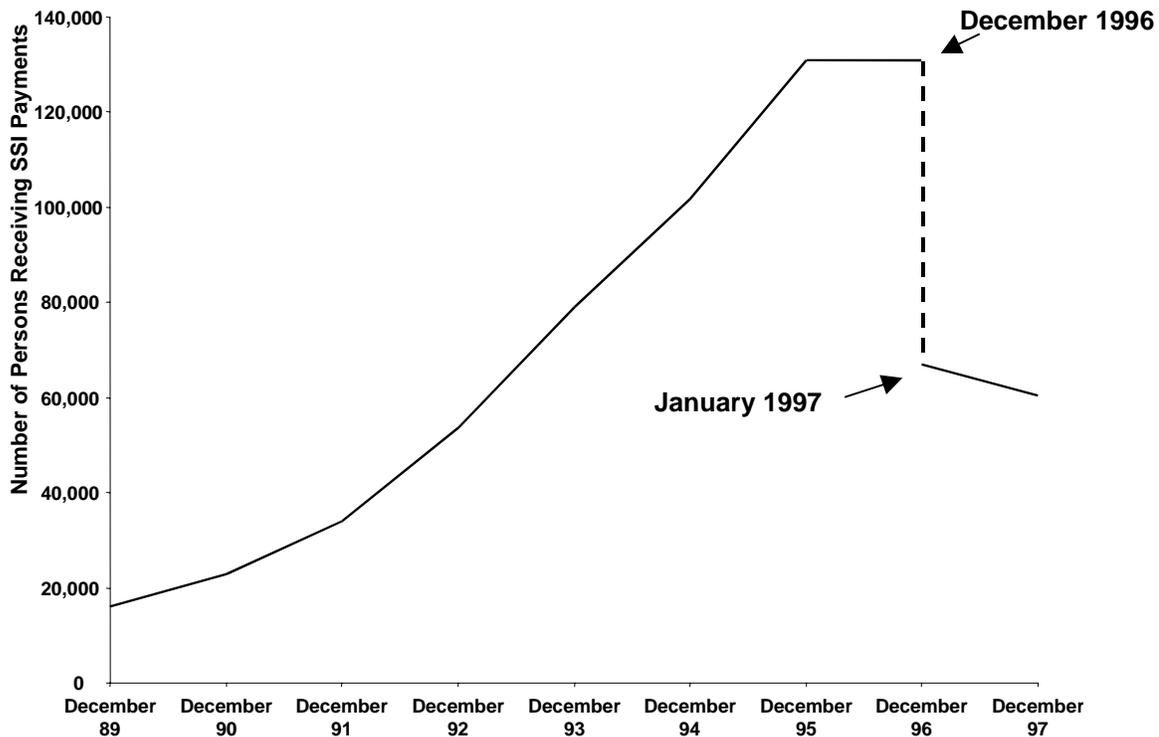
¹⁷ As discussed in Section III.B, efficient claims processing requires examiners to allow cases on the basis of the most easily determinable impairment, and because substance abuse impairments of sufficient severity to meet SSA's past eligibility criteria were sometimes easier to verify than other impairments, at least some allowances were classified as DA&A cases that, had additional evidence been available to the examiner, might not have been placed in this class. Further, some beneficiaries who were substance abusers, but whose abuse was not material to DA&A, may have been classed as DA&A to provide them with better access to treatment, through an RMA.

¹⁸ Lewin (1997a)

implementation projections (see Section II.D.2). Deterioration in the currently robust economy might, however, reverse recent trends and result in many more claims and allowances.

The rate at which beneficiaries retained benefits differed significantly between the SSI and DI-only groups. Within the SSI group, 35.5 percent, or approximately 55 thousand beneficiaries, had been found medically eligible. Among SSI beneficiaries who were in SSI current pay status for April 1996, 37.5 percent had been determined to be medically eligible.¹⁹ In addition, 24 percent of SSI beneficiaries who were not in SSI current pay status for April 1996 had been found medically eligible. Concurrent beneficiaries were almost as likely to maintain medical eligibility as SSI-only beneficiaries (34.1 percent vs. 36.0 percent). The number of targeted beneficiaries who received SSI payments in December 1997 is comparable to the total number of SSI DA&A beneficiaries receiving payments in December 1992 (**Exhibit II.4**).²⁰

Exhibit II.4
DA&A Beneficiaries and Former DA&A Beneficiaries Receiving SSI Payments, 1989-1997



Source: Barber (1996) for December values from 1989 through 1995 and Lewin Group analysis of SSA's 10% SSI DA&A Tracking File for December 1996, January 1997, and December 1997. The eligibility of a substantial number of those receiving payments in January 1997 was suspended because their reapplications were still pending. See Section II.D.2.

¹⁹ Similarly, 36.5 of SSI beneficiaries who received either a federal SSI payment, a State supplement, or a DI payment were determined to be medically eligible as of December 1997.

²⁰ The decline in the number of individuals receiving SSI payments between January and December 1997 reflects the cessation of continuation payments to former DA&A beneficiaries whose reapplications were denied.

Within the DI cohort, 28.6 percent, or just over 12 thousand beneficiaries, retained medical eligibility. DI beneficiaries who received DI benefits for March 1996 were more than three times as likely to be found medically eligible than DI beneficiaries who did not receive DI benefits for March 1996 (29.7 percent vs. 9.0 percent).²¹ The share of Never SSI beneficiaries that retained medical eligibility was markedly larger than the corresponding share of Serial beneficiaries (31.7 percent vs. 25.1 percent).

The number not medically eligible overstates the number whose benefits were terminated because of the new policy, because benefits of some of those who were in payment in March 1996 would have been terminated by December 1997 in the absence of a policy change. Further, some of those not determined medically eligible by December 1997 will have their benefits reinstated at a later date, in some cases retroactively.

In what follows, we develop and present our first-cut estimates of the impact of the policy change on caseloads as of December 1997. Later in the project, we will develop more refined estimates of the full impact of the policy change on the caseloads, including projections of re-entry after December 1997. The first-cut estimates are conservative, for three reasons. First, we adopt conservative assumptions to estimate the impact on the 209 thousand targeted beneficiaries. Second, we do not consider the impact on allowances after the 1996 legislation was passed. Third, we do not consider increases in terminations or reductions in allowances that pre-dated passage of the 1996 legislation, either in anticipation of that legislation or as a result of the 1994 legislation.

In developing our first-cut estimates, we first developed assumptions for the percent of targeted beneficiaries whose benefits would have been terminated anyway in the 21-month period from March 1996 through December 1997, based on findings reported by Rupp and Scott (1995) for SSI-only cases. For DI-only and concurrent cases, we supplemented the findings of Rupp and Scott with information from Hennessey and Dykacz (1989). Details of how we developed the estimates appear in **Appendix I**. In developing the counterfactual termination rates, we assumed that termination rates for DA&A cases would be similar to those for all psychiatric cases. Historical rates for beneficiaries with psychiatric impairments have been substantially lower than for most other cases. Also, because termination rates conditional on a specific duration of participation (“hazard rates”) are normally higher for short durations than for long durations, and because duration for most targeted beneficiaries was relatively short as of March 1996, the rates we develop have been adjusted for duration. They are not, however, adjusted for other factors, and could be substantially incorrect. In future analysis we will develop more accurate estimates, based on an original analysis of past termination rates for DA&A beneficiaries.

Based on this analysis, we estimate that roughly 20 percent of all targeted SSI-only beneficiaries would have had their benefits terminated as of December 1997 in the absence of reform. The figure we use for DI-only cases is 10 percent, primarily reflecting lower historical terminations for DI cases with psychiatric impairments than for SSI-only cases. The fact that the average duration for targeted DI-only cases as of March 1996 was one year longer than for SSI-only cases also contributes to the lower termination rate assumption. For concurrent cases we use the

²¹ This comparison includes DI beneficiaries who may have been paid retrospectively for March 1996.

midpoint between the DI-only and SSI-only assumptions, 15 percent. Although not certain, we think that these rates are, if anything, somewhat too high.²²

As a first cut, we estimate that 49 percent of the targeted beneficiaries lost their benefits as a result of the new policy as of December 1997 – about 103 thousand individuals (**Exhibit II.5**). Another 17 percent (35 thousand) lost their benefits over this period, but we attribute these terminations to other factors. Although most of those estimated to have lost benefits because of the policy were SSI beneficiaries (77 thousand), we estimate that the percent losing benefits because of the policy was substantially higher for DI-only cases (62 percent vs. 46 percent for SSI), reflecting both a smaller percent medically eligible in December 1997 and relatively low historical termination rates.

Exhibit II.5
Estimated Number of Target Beneficiaries Medically Eligible and Terminated,
December 31, 1997

	DI-only			SSI			Total
	Total	Never SSI	Serial	Total	Only	Con-current	
Targeted Beneficiaries	42,762	22,489	20,273	166,612	119,949	46,663	209,374
Number Medically Eligible	12,204	7,115	5,089	59,089	43,104	15,985	71,293
Percent Medically Eligible	28.5%	31.6%	25.1%	35.5%	35.9%	34.3%	34.1%
Number Terminated	30,558	15,374	15,184	107,523	76,845	30,678	138,081
Percent Terminated	71.5%	68.4%	74.9%	64.5%	64.1%	65.7%	65.9%
Assumed Counterfactual Termination Rate	10.0%	10.0%	10.0%	18.6%	20.0%	15.0%	16.8%
Estimated % Terminated Due to Policy Change	61.5%	58.4%	64.9%	45.9%	44.1%	50.7%	49.1%
Estimated Number Terminated Due to Policy Change	26,282	13,125	13,157	76,534	52,855	23,679	102,816
Percent of Terminations Due to Policy Change	86.0%	85.4%	86.6%	71.2%	68.8%	77.2%	74.5%
Reapplications and New Claims Denied	18,668	9,353	9,315	61,394	44,216	17,178	80,062

Source: Lewin Group analysis of SSA's DA&A Universe File, MBR and SSR.

As a check on the reasonableness of the first-cut estimate, we calculated the number of targeted beneficiaries who had filed a reapplication or new claim before the end of 1997, but who had been denied. We view the estimate, about 80 thousand cases, as a lower bound on the number whose benefits were terminated by the legislation because these beneficiaries had shown a clear

²² See Appendix I for discussion.

interest in continuing to receive benefits.²³ Our first-cut estimate of 103 thousand is higher, but seems quite reasonable, because presumably some beneficiaries who lost their benefits involuntarily failed to reapply or file a new claim.

2. The Dynamics of the Appeal and Termination Processes

In this section we analyze the dynamics of the appeal and termination processes. The analysis is motivated by both policy and methodological issues.

The policy change potentially imposed substantial costs on targeted beneficiaries whose substance abuse was not material to their disability despite their DA&A status. The size of these costs is related to how quickly cases were reviewed and determined. At one extreme, if every case identified as a potential DA&A case had been identified and correctly redetermined instantaneously, the costs imposed on such individuals would have been negligible. The reality though, is that some who were eligible for continuing benefits did not file immediately, and substantial time was needed to process the appeals of those who did file. Although the law included provisions for continued benefits to those who filed timely appeals, many who were eligible for continued benefits may have experienced short-term benefit loss because they failed to file timely appeals, or because their appeal was not initially allowed. A related policy issue is that some, perhaps many, of the targeted beneficiaries who were not eligible in December 1997 may re-enter SSI or DI in the near future, reducing the impact of the policy change on terminations.

The methodological issue is related. In the future, we plan to estimate “termination models,” to be used in refining our impact estimates. Termination, however, is not cleanly defined when eligibility is suspended, and eventually either re-instated retroactively or terminated. This is further complicated by the fact that some beneficiaries’ continued receiving payments after eligibility suspension. How we choose to define termination could have a substantial effect on the impact estimates. Knowledge about the paths of various participation measures over the transition period should be helpful in designing and interpreting the termination analysis.

In what follows, we analyze the dynamics of reapplications, new claims and allowances for targeted SSI recipients. We have been unable to conduct comparable analyses for DI-only cases. Although we would expect the dynamics to be similar for DI-only cases, differences in the characteristics of DI-only and SSI beneficiaries as well as programmatic differences might result in a substantively different picture.²⁴

We focus on three issues:

²³ This estimate excludes reapplications and new claims whose final decisions were pending as of December 31, 1997. We estimate that there were no reapplications and about 3,400 new claims for SSI pending as of December 31, 1997. We do not know, however, the number of DI reapplications or new claims pending.

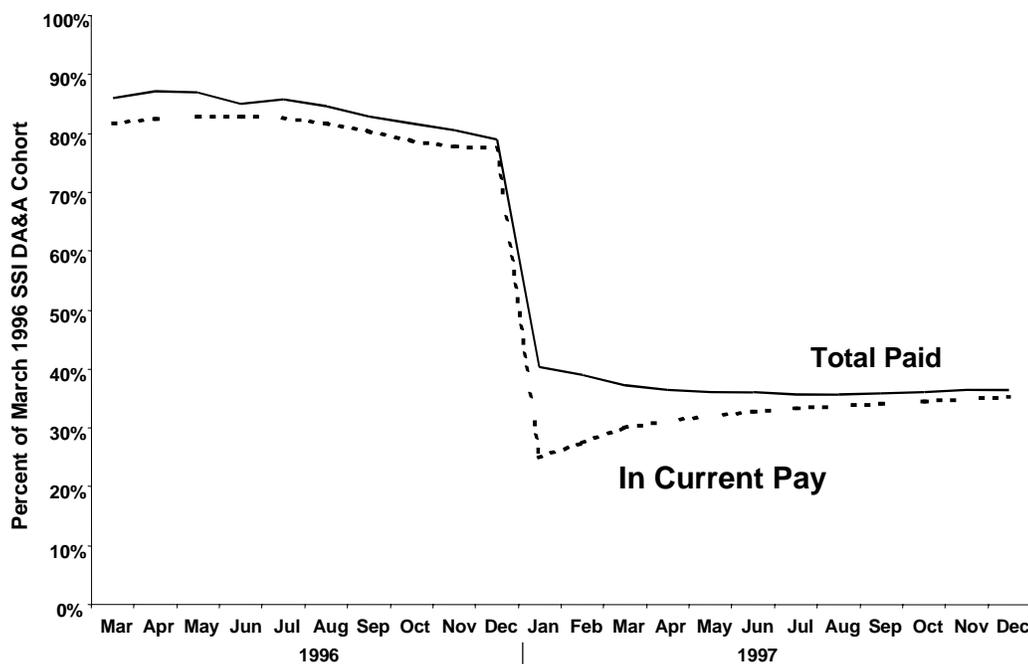
²⁴ One possibly important difference is that DI-only beneficiaries who filed timely appeals were only guaranteed continuation of benefits through the initial determination stage, whereas SSI beneficiaries who filed timely appeals were guaranteed benefits through the redetermination stage. Hence, DI-only beneficiaries who filed timely appeals may have been more likely to have interrupted payments if an allowance was not made before January 1997.

- The monthly eligibility and payment status of SSI DA&A beneficiaries from March 1996 through December 1997. This analysis shows dynamics of “terminations” by two different termination measures – one loss of eligibility for current payment and the other loss of actual payments (including current, retroactive, and/or forced payments);
- Temporary interruptions in actual payments to targeted beneficiaries who were determined to be medically eligible by the end of 1997, but not at the beginning. Presumably such beneficiaries suffered the most substantial costs of the new policy among those determined to be eligible by the end of the year; and
- The number and timing of reapplications and new claims. This analysis provides information about both the extent to which individuals waited until after the appeal period to seek continuation of benefits and the extent to which additional targeted beneficiaries will re-enter the program in the near future.

a) Monthly Eligibility and Payment Status of Targeted SSI Beneficiaries

Based on a 10 percent random sample of the March 1996 SSI cases, we find that SSI payments were actually made to only 85.9 percent of these beneficiaries in March 1996 (the “total paid” series in **Exhibit II.6**). As previously indicated, however, this understates the number who received a benefit payment of some sort because many received a DI payment. We also find that a smaller share were in current pay status -- 81.7 percent -- indicating that some who received payment did so on the basis of past, rather than current eligibility.

Exhibit II.6
Current Eligibility and Payment Status of Targeted SSI Beneficiaries, March 1996 through December 1997



Source: Lewin Group analysis of SSA’s 10% SSI DA&A Tracking File. See Exhibits App.I.11 and App.I.13.

While there were slight declines in both the share paid and the share in current pay status through the end of 1996, there was no change in the payment or current pay status in the vast majority of cases until January 1997. In that month, both payment and eligibility ended for many, at least temporarily. The percent to whom payments were actually made dropped by 38.6 points, representing about 64 thousand people, and the percent in current pay dropped even more sharply, by 52.4 points, representing about 87 thousand people.

From January through December 1997, the percent in current pay status gradually increased, from 27.9 percent to 35.3 percent, reflecting allowances made on pending cases. The percent receiving payment declined through August 1997, however, reflecting the fact that payments were ended to those receiving denials, at least once their appeals were past the redetermination level. The August value for the percent actually paid is the minimum value, 35.6 percent. From then on, this number increases, but at a slower rate than the percent in current pay, reaching 36.4 percent in December. The overall decline in the percent receiving payments between January 1997 and December 1997 is also apparent in **Exhibit II.4**.

Based on the slope of the current pay status line in the last months of 1997, it appears that the percent of targeted SSI recipients who are currently eligible will continue to grow for at least the first few months of 1998, as additional cases make their way through the adjudication process, but at a fairly low rate – 0.3 to 0.5 percentage points per month. Data on appeals, new claims, and pending claims, presented later in this section, provide additional support for this expectation.

b) Payment Interruptions to Targeted SSI Beneficiaries Determined to be Medically Eligible by December 1997

SSA determined that about 25 percent of targeted SSI beneficiaries were eligible for continued benefits in the nine-month period from the passage of the legislation through January 1997. This is 74 percent of the number that would be determined to be eligible by the end of 1997. Thus, a substantial majority of those determined to be eligible by that date had no interruption in either current pay status or actual payments. Given the large workload that adjudicators were burdened with even in the absence of the policy change, the time needed to identify and notify claimants, and the training necessary to properly adjudicate the DA&A appeals, this share is remarkably high. By the end of March 1997, 90 percent of those allowed by the end of the year had been reinstated, and by the end of June that figure had increased to almost 97 percent. Thus, only 10 percent of those found to be medically eligible by the end of the year had an eligibility interruption of longer than six months.

Many of those SSI beneficiaries with eligibility interruptions continued to receive payments for all, or a substantial share of, the period during which they were not in current pay status. Most of those represented by the difference in the “total paid” and “current eligibility” series in each month from January through December 1997 benefited from continuation payments (**Exhibit II.6**).²⁵

²⁵ See Exhibit App.I.12.

Exhibit II.7
Months without Payment for SSI DA&A Beneficiaries Who Had a Reapplication Pending on January 1, 1997 and Were Allowed by December 31, 1997

	Total	SSI-only	Concurrent
Number of Cases	13,980	10,490	3,490
Percent of Reapplications Filed	11.7%	12.3%	10.1%
Percent of Target Cases	8.4%	8.8%	7.5%
Number of Months without Pay			
0	33.5%	36.5%	24.6%
1-3	28.3%	29.9%	23.2%
4-6	14.7%	15.3%	12.6%
7-9	9.7%	9.0%	11.7%
10-12	13.9%	9.2%	27.8%
Mean	3.5	3.0	5.1

Source: Lewin Group analysis of SSA's DA&A Universe File and 10% SSI DA&A Tracking File.

Of the almost 16 thousand targeted SSI beneficiaries who were medically eligible at the end of 1997, but not at the beginning, nearly 14 thousand had filed reapplications. The remainder obtained an allowance on the basis of a new claim, and therefore were not eligible for continuation payments. Of those reapplying, 33.5 percent had no interruption in payment before they received their allowance (**Exhibit II.7**). Another 43 percent had interruptions lasting up to six months, and the remaining 24.5 percent had interruptions lasting from seven to twelve months. Overall, about 9,300 SSI reapplicants (7.7 percent) had a payment interruption. While the harm that payment interruption may have caused these individuals should not be minimized, this number is remarkably low given the complexity of the undertaking.

c) The Dynamics of Reapplications, New Claims and Pending Decisions for Targeted SSI Beneficiaries

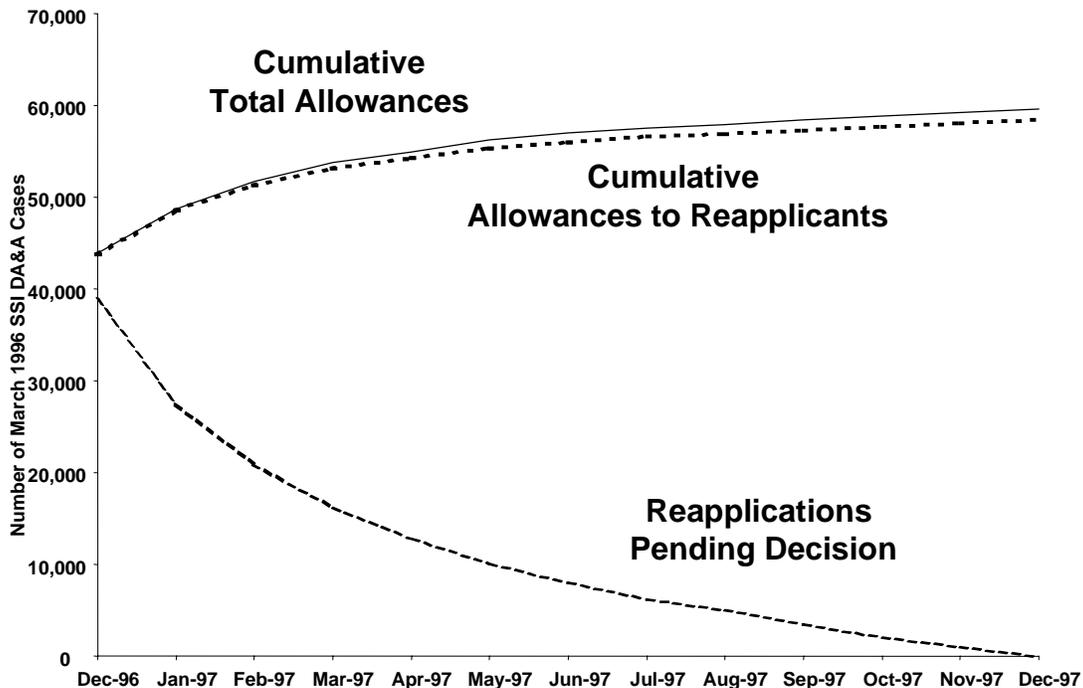
Many of the targeted beneficiaries lost their benefits in January 1997 without filing a reapplication. Based on the 10% Tracking File, almost 120 thousand of the SSI cases (72 percent) had reapplied by that date (**Exhibit II.8**), leaving 46 thousand that did not. Of those who reapplied, about 37 percent retained eligibility on January 1, 1997, and almost half (48.8 percent) had obtained eligibility by the end of December 1997.²⁶ About 39 thousand reapplications were pending decisions at the end of 1996, but this number dropped rapidly in the next five months and we found no pending cases in the 10% file in December 1997.

As discussed further in Chapter III, case study informants gave several reasons why notified beneficiaries did not appeal -- failure to receive the notice due to unstable addresses; lack of another impairment; a mistaken belief that the notice was triggered by failure to comply with RMA requirements; inability of the beneficiary to respond because of their impairment; and, in a

²⁶ Allowances to reapplicants by December 1997 include allowances made on new claims that were filed by about 15,100 reapplicants after they had stopped pursuing their reapplications.

few instances, return to work. Some administrators and advocates had expected beneficiaries to wait until benefits were actually lost before filing a claim.

Exhibit II.8
Estimated Reapplications Pending Decision and Allowances to Reapplicants

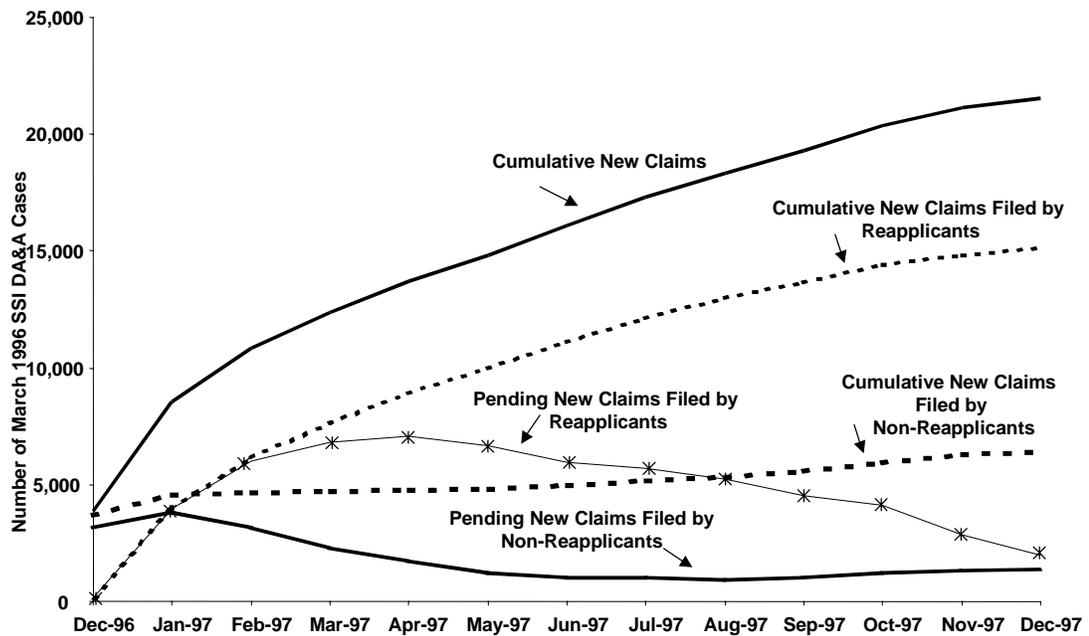
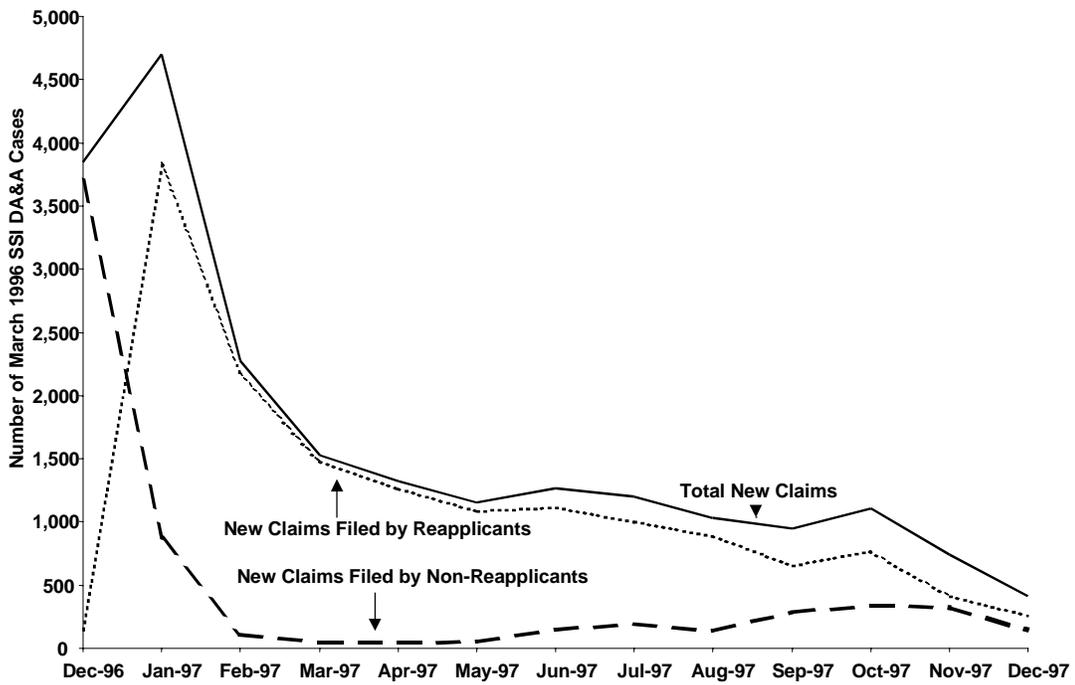


Source: Lewin Group analysis of SSA's DA&A Universe File and 10% SSI DA&A Tracking File. See Appendix Exhibit App.I.14.

In fact, the number of new claims filed by targeted SSI beneficiaries who never reapplied has been fairly small – only 6,440 by the end of 1997, about 14 percent of those that did not file a reapplication (**Exhibit II.9**). There was a brief surge of new filings near the end of 1997, which declined sharply to under 100 by March. The monthly number grew again in the Fall, but peaked in October at just over 300 and was less than half of that in December. The small number filing new claims after losing benefits suggests that most who did not reapply believed, rightly or wrongly, that they would not be eligible if they had. Another possibility is that the strong economy provided them with employment opportunities or other sources of support that made return to SSI a less attractive option, at least temporarily.

New claims from those who had unsuccessfully reapplied were more numerous than claims from those who had not reapplied, reaching more than 15 thousand by the end of 1997. Again, however, the number of new filings each month was very low by the end of the year. As mentioned earlier, the small number of pending cases at the end of 1997 (about 2,000), along with the small and diminishing number of claims filed in the last few months of 1997 (about 460 in December) suggests that growth in the percent of targeted SSI recipients who have established medical eligibility will continue to be low in the early part of 1998.

EXHIBIT II.9
New Claims Filed and Pending for Targeted SSI Beneficiaries



Source: Lewin Group analysis of SSA's 10% SSI DA&A Tracking File. See Appendix Exhibit App.I.14.

3. Characteristics Related to Continuation of Benefits

We compared the characteristics of those in the March 1996 DA&A cohort who were medically eligible in December 1997 to those who were not. While many characteristics observed in the administrative data were somewhat predictive of medical eligibility, none clearly differentiated those who obtained continued eligibility from those who did not.²⁷ Statistically significant differences of interest are reported below for demographic, earnings and participation, and impairment characteristics. Where possible, we report findings for all cases that we analyzed. Due to data limitations, some findings are reported for SSI cases only, and one finding is reported for just DI-only cases.²⁸

a) Demographics

We found the following differences in the percent medically eligible in December 1997 among demographic subgroups:

- Women were more likely to be eligible than men (37.4 vs. 32.7 percent);
- Percent eligible increases with age (from 14.8 percent for those under 18 to 46.4 percent for those over 59);
- Among those for whom we have race data, whites were more likely to be eligible (35.3 percent) than blacks (31.6 percent) and others (32.9 percent); and
- Those relatively few SSI recipients identified as living in an institution or Medicaid facility in March of 1996 had a very high eligibility rate (55.7 percent). Those living in their own household were more likely to be eligible than average (36.1 percent) and those living in a parent's household were least likely to be eligible (13.0 percent).

The percent medically eligible among the 1.0 percent of the SSI DA&A recipients identified as aliens is almost identical to that for citizens.

Most demographic characteristics captured in the Maximus data appear to be rather poor predictors of medical eligibility. A notable exception is that those living with children under 18 were less likely to be medically eligible in June 1997 (28.3 percent for those with children vs.

²⁷ All "percent medically eligible" figures reported in this section for a group are significantly different than the average for the larger group from which they are drawn (the entire March 1996 analysis cohort, SSI cases, or DI-only cases). That is, the probability of drawing a random subgroup of the same size with a value for percent medically eligible that deviates as much as that observed from the larger group's value is less than 5.0 percent -- much less in some cases. Percent medically eligible is reported for many other subgroups in Exhibit App.I.7 and App.I.8 in the appendix. Many of the values reported are also significantly different than the value from the relevant larger group, but these differences are substantively of less interest or essentially reflect differences reported here.

²⁸ See Exhibits App.I.7 and App.I.8.

32.9 percent for those without children).²⁹ This may reflect the availability of alternative cash benefits through TANF.

b) Earnings, Employment, and Program Participation Histories

Those whose participation in the labor force was greatest in March 1996 were among the most likely to have had their benefits terminated, although the evidence we have is based on SSI cases only. We speculate that these individuals were both in the best position to rely on earnings as a primary source of income and least likely to have a severe comorbidity.

Among the SSI recipients, there is a strong inverse relationship between monthly earnings in March 1996 and December 1997 eligibility. Only 12.7 percent of those in the highest earnings category (\$500 per month or more) were eligible (1.2 percent of SSI cases), compared to 35.8 percent of those with no earnings (97.5 percent of SSI cases) and 35.1 percent of those with some earnings, but under \$150. One explanation for this relationship may be that those in the highest earnings category were least likely to be in payment in March 1996. This category includes most section 1619 cases, including the 0.6 percent of cases that were in section 1619(b). These cases are eligible for SSI, but receive no payment because of their relatively high earnings. Of the March 1996 DA&A cases in section 1619(a) and (b), only 14.3 and 13.7 percent, respectively, were medically eligible in December 1997.

There is also a strong positive relationship between duration of benefit receipt as of March 1996 and medical eligibility as of December 1997. Of all DA&A beneficiaries on the rolls for one to two years, only 32.4 percent were eligible, compared to 45.4 and 45.3 percent, respectively, for those on the rolls for 12 to 14 years and 15 or more years. It seems likely that this relationship reflects an increase in severe comorbidities as beneficiaries age. It does not seem to reflect a change in the nature of new cases in conjunction with implementation of the 1994 policy; the percent medically eligible among those on the rolls for three to five years as of March 1996 – cases allowed after 1990 but before 1994 – is only slightly higher than the percent for those on the rolls for one to two years (32.7 vs. 32.4).

The generally strong positive relationship between December 1997 medical eligibility and March 1996 duration is reversed for duration under one year. Medical eligibility for those who had never received a payment is 37.6 percent and for those with payments for less than one year is 34.0 percent. Evidently those allowed in the months leading up to March 1996 were more likely to have had a qualifying co-morbidity than those in prior years. Possible explanations include: 1) a decline in claims from those who would qualify only under the DA&A classification, as a consequence of past or anticipated policy change or of the strong economy; or 2) administrative tightening of DA&A eligibility as a result of a change in the “adjudicative climate” in such cases (i.e., administrative and policymaker concern about growth in such cases, as well as court

²⁹ The analysis of medical eligibility for Maximus cases is through June 1997 only, because eligibility data through December 1997 were unavailable when we analyzed the Maximus data. We chose not to repeat the analysis using data for December 1997, because the analysis of the SSA administrative data suggested that factors predictive of medical eligibility in June 1997 were also predictive of medical eligibility in December 1997. Overall, 32.2 percent of Maximus cases were medically eligible in June 1997, as compared to 32.0 percent for the entire DA&A cohort.

decisions unfavorable to claimants, encouraged adjudicators to tighten the application of eligibility rules).

Consistent with the inverse relationship found between earnings in March 1996 and medical eligibility in December 1997, the analysis of the Maximus data found that individuals with more education and technical training were less likely to be medically eligible in June 1997. The analysis did not produce any strong connection, however, between medical eligibility and previous occupation. We also found that individuals with no criminal background were much more likely to be medically eligible in June 1997 than individuals who had been charged with one or more offense (39.4 percent vs. 31.3).

Findings from the case studies (Chapter III) suggest that representative payees may have played an important role in helping targeted beneficiaries file appeals. The interest and ability of representative payees to provide assistance may be related to representative payee type. In fact, for SSI cases we found significant variation by representative payee type that is consistent with this hypothesis, although not cleanly interpretable; we did not have data for DI-only cases.

For SSI recipients, the relatively small number with no representative payee in March 1996 were least likely to be eligible in June 1997 (29.7 percent). Among those with representative payees, those with a child representative payee (only 4.1 percent of cases) had a much higher eligibility rate than others (45.7 percent). Those in mental institutions and those with public official representative payees also had very high rates, but the numbers in each group are very small. Those with a spouse or parent representative payee – about one quarter of all cases -- had low eligibility rates (33.0 and 32.3 percent, respectively).

Another interesting finding is a strong positive relationship between the decision level at which the award in effect in March 1996 was made and medical eligibility in June 1997. While 33.9 percent of those whose earlier award was made at the initial determination level were eligible, 41.9 percent who received their earlier award from the Appeals Council were eligible. Values for reconsideration and hearing awards were intermediate to these. This relationship may reflect the relative severity or complexity of allowances made on appeal, although one might expect that the most obviously severe cases would be allowed at the initial level. Another, perhaps more plausible, explanation is that this relationship reflects the motivation of the individual to obtain benefits. That is, those receiving earlier allowances only after appeal were a highly motivated group, and that same motivation led them to vigorously pursue continuation of benefits.

c) Impairments

As may have been anticipated, those whose impairment classification for eligibility purposes in March 1996 was substance abuse were less likely than those in other classifications to be medically eligible in December 1997, although differences may not be as striking as one might expect. Of SSI recipients in the substance abuse category, 32.8 percent were medically eligible in December 1997, compared to 35.5 percent for all SSI cases.³⁰ Those in the schizophrenia

³⁰ We do not have March 1996 impairment data for DI-only cases.

category had the highest eligibility rate (50.5 percent), and rates were also high for those in the infectious/parasitic disease and other psychosis categories (44.8 and 43.6 percent, respectively).

We also found that the 3.6 percent of SSI cases classified as “permanently disabled” in March 1996 were more likely to be eligible in December 1997 than those in the not permanent category (49.4 vs. 34.9 percent). We had expected a larger share of those with permanent disabilities to retain benefits on the assumption that, if substance abuse were material to disability, ending substance abuse would end disability, at least at a qualifying level of severity. It may be that a substantial share of those in the permanent disability group failed to appeal or file a new claim.

The Maximus data reveal large differences in medical eligibility rates across substance abuse and medical severity categories. Maximus cases in the “no real” or “none” substance abuse categories were much more likely to be medically eligible in June 1997 than cases with an extreme substance abuse problem (41.9 vs. 28.2 percent). In contrast, cases with an extreme medical problem were more likely to be eligible than cases with no medical problem (39.3 vs. 27.7 percent). An examination of the relationship between medical eligibility and the combinations of medical severity with substance abuse severity revealed that, with the exception of cases with missing information, those with the most extreme medical severity problems and no substance abuse problems were more likely than any other group to be medically eligible (50.1 percent). Similarly, those beneficiaries with no medical problems and extreme substance abuse problems were least likely to be medically eligible (23.3 percent).

d) Changes in Impairments

Many people with substance abuse disorders have psychiatric co-morbidities, so it was widely anticipated that many DA&A beneficiaries would retain eligibility on the basis of such a co-morbidity. Impairment data for SSI cases confirm this.³¹ Of those who were medically eligible in December 1997, 58 percent were eligible on the basis of a psychiatric impairment, including 27 percent with an affective disorder, 21 percent with schizophrenia or some other psychoses, and 9 percent with a neuroses that was not an affective disorder. The 42 percent whose disorders for continuing eligibility were non-psychiatric include ten percent in the mental retardation category, eight percent in the musculoskeletal category, and five percent in the circulatory category.³²

E. Cross-State Variation

1. Participation in March 1996

Previous SSA reports on the SSI DA&A caseload have shown substantial cross-state variation in participation rates (Barber, 1996). We examined both the distribution of the March 1996 DA&A cohort by state and the number of beneficiaries per hundred thousand adults age 18-64 (“prevalence”) by state.³³ Our analysis revealed cross-state variation for both SSI and DI DA&A

³¹ Comparable data are not available for DI-only cases.

³² See Exhibit App.I.10.

³³ See Exhibits App.I.4 and App.I.5.

cases similar to that found in earlier analyses. In addition, we analyzed the distribution and prevalence of DA&A beneficiaries across Census regions and divisions as well as across the circuits of the U.S. Courts of Appeals.

Findings for SSI recipients are essentially the same as findings reported previously by Barber (1996) for December 1995 recipients. A very large share of all beneficiaries were in a small number of states. The ten states with the largest shares were California (24.0 percent), Illinois (12.2 percent), Michigan (7.8 percent), New York (5.2 percent), Ohio (4.8 percent), Tennessee (4.4 percent), Kentucky (3.5 percent), Massachusetts (3.6 percent), Pennsylvania (3.1 percent), and Washington (2.4 percent) – collectively accounting for 71.0 percent of SSI cases. The two Census divisions with the most cases accounted for 56.3 percent: East North Central (28.2 percent) and Pacific (28.1 percent).

Findings for the DI-only cohort are similar, but there were relatively more such beneficiaries in the Northeast and South, relatively fewer in the West, and concentration in a small number of states was not as great. This difference in the pattern was especially true for Never-SSI recipients; the distribution for Serial recipients was much more similar to that for SSI recipients. The ten states with the largest shares of DI-only recipients were California (12.4 percent), Illinois (10.9 percent), Michigan (6.7), New York (5.5 percent), Tennessee (4.8 percent), Massachusetts (4.7 percent), Ohio (4.3 percent), Kentucky (3.0 percent), Florida (3.0 percent), and Pennsylvania (2.6 percent) – collectively accounting for 57.9 percent of DI-only cases. The two divisions with the most cases accounted for 44.4 percent: East North Central (26.6 percent) and Pacific (17.8 percent).

Variation in state shares substantially reflects variation in population size, but participation rates (number per 100,000 population age 18-64) also varied widely. Considering SSI and DI-only cases together, the national participation rate was 123. Illinois had the highest rate (328) and was the only state with a rate of more than 300. Six other states had rates in excess of 200: Kentucky (280), Tennessee (270), Michigan (257), West Virginia (220), California (219), and Massachusetts (201). The entire East North Central division also had a rate in excess of 200 (209), while the East South Central and Pacific divisions had rates that were slightly lower (198 and 197, respectively). In contrast, several states had rates of 50 or less per hundred thousand: Texas (22), Wyoming (37), New Jersey (38), Utah (44), Colorado (47), Delaware (47), Louisiana (48), Iowa (49), Florida (50). In fact, the rate for the entire West South Central division, dominated by Texas, was 32.3.

One theory for this cross-state variation is that state participation rates reflect the decisions of U.S. Courts of Appeals on the allowances of drug and alcohol abuse cases. Dr. James Baumohl, a historian of SSA DA&A policy, identified a 1987 Ninth Circuit ruling, *Cooper vs. Bowen*, as a case that “opened the floodgates” for DA&A awards in the Ninth Circuit, and seemingly established a precedent for later decisions in the Seventh and Sixth Circuits.³⁴ Because the effect of a major ruling such as this may gradually spread across all circuits, the effect of such decisions on participation rates at the court of appeals level may be less evident in 1996 than in earlier years. For example in December 1991, California, which is located in the Ninth Circuit,

³⁴ Baumohl (1997).

and Illinois, which is located in the Seventh Circuit, accounted for over half the SSI DA&A caseload.³⁵ By March 1996, however, these two states' combined share of the caseload had fallen to 36 percent. Nevertheless, participation rates in March 1996 ranged from 223 per 100,000 in the Seventh Circuit to 34 per 100,000 in the Fifth Circuit. Furthermore, participation rates were substantially higher in the Ninth, Seventh, and Sixth Circuits, as well as the First Circuit, than in any other circuits.

While participation rates by circuit did vary substantially, closer examination shows that circuit boundaries did not cleanly divide states into high and low rate groups. The Seventh Circuit rate, for example, is dominated by the extremely high rate for Illinois (328); the other two states have rates that are near the national rate (122.5). In the Sixth Circuit, which had the second highest rate, three of the four states had rates above 250, while the fourth had a rate that was slightly above the national average, lending credence to the courts of appeals hypothesis. We note, though, that West Virginia, an adjacent state which was in the low-rate Fourth Circuit (76), had a rate of 220. Two other circuits with very high rates are, like the Seventh Circuit, dominated by one state with an exceptionally high rate, but include states with rates below the national average – the First Circuit (dominated by Massachusetts) and the Ninth Circuit (dominated by California). The fact that circuits do not cleanly divide states into high and low rate groups may reflect state idiosyncrasies, gradual spreading of the influence of court decisions, and more recent court decisions that may have had a negative impact on caseload growth.³⁶

Legislation already passed by the U.S. House of Representatives and, as of April 21, 1998, awaiting action in the Senate (The Federal Agency Compliance Act, H.R. 1544) is aimed, at least in part, at increasing the uniformity of disability program determinations across jurisdictions. The Act would allow SSA and other federal agencies, in specific circumstances, to pursue policy or litigation within a judicial circuit that opposes the existing precedent regarding the interpretation and application of a given statute, as established by the U.S. Court of Appeals for that circuit. The Act also instructs federal agencies to avoid “unnecessarily repetitive litigation on questions of law already consistently resolved against the position of the United States, or an agency or officer thereof, in precedents established by the United States Courts of Appeals for three or more other judicial circuits.” If, as the data suggest, cross-state variation in participation rates for DA&A cases reflects early courts of appeals decisions that were favorable to DA&A claimants, more uniform treatment of such cases would most likely have resulted in a DA&A caseload expansion that was even more rapid than the actual expansion.

As discussed further in Section III.2, the extent to which adjudicators made allowances for substance abuse rather than fully assess other possible disorders may have also contributed to cross-state variation in prevalence rates. Because substance abuse impairments of sufficient severity to meet SSA's past eligibility criteria were easier to verify than other disabilities that some beneficiaries had, there were beneficiaries who were classified as DA&A cases that, had additional evidence been available to the examiner, might not have been placed in this class. Further, some beneficiaries who were substance abusers but whose abuse was not material to DA&A may have been classified as DA&A to provide them with better access to treatment

³⁵ HHS/OIG (1991).

³⁶ *Dotson vs. Shalala* in the Seventh Circuit, 1993; *Corrao vs. Shalala* in the Ninth Circuit, 1994.

through an RMA. Moreover, as suggested in GAO (1994), DDSs in states that had established RMAs in the late 1980s and early 1990s, such as California, may have given a higher priority to the identification of DA&A cases than DDSs in states without RMAs.

It is also reasonable to suspect that the socio-economic characteristics in certain states and localities played a sizable role in producing cross-state variation. For example, it is likely that the chronic poverty in Appalachia contributed to the high DA&A prevalence rates in Kentucky, Tennessee, and West Virginia. Similarly, the “de-industrialization” in the “Rust Belt” and the associated high unemployment rates over a long period may have contributed to the high prevalence rates in the East North Central Census division. Finally, both California and Massachusetts were hit particularly hard by the recession of 1990-91. California’s annual unemployment rate exceeded 7.5 percent from 1991 through 1995, peaking at 9.4 percent in 1992 and 9.3 percent in 1993. Likewise, Massachusetts’ unemployment rate increased by over three percentage points between 1990 and 1991, to 9.1 percent, and continued at a high level through 1992.

Finally, it is possible that the cutbacks in state general assistance (GA) programs that began in many states in the early 1990s may have led many drug addicts and alcoholics to seek SSI benefits. Stapleton and Livermore (1996) provides support to the theory that changes in local assistance programs can affect SSI applications and awards. According to simulations based on the model developed in Stapleton and Livermore (1996), elimination of Michigan’s GA program accounted for 34 percent of all SSI application growth and 49 percent of growth in the mental impairment category in Michigan between 1988 and 1992. In addition to Michigan, several other states with high DA&A prevalence rates cutback or eliminated their GA programs for people with disabilities, including Illinois, Massachusetts, and Ohio.

2. Medical Eligibility in December 1997

Medical eligibility in December 1997 varied substantially across states, regions, divisions, and U.S. Courts of Appeals circuits.³⁷ The rate of medical eligibility was much higher in the Northeast (44.3 percent) than in any other region; the rate was second highest in the West (33.2 percent) and lowest in the South (29.7 percent). Cross-state variation ranged from a low of 19.5 percent in Tennessee to a high of 51.0 in New York. Differences across neighboring states that are often considered to be similar in many respects are high: Kentucky’s eligibility rate was 14.5 percentage points higher than Tennessee’s; Michigan’s was 13.6 points higher than Illinois’ and 12.1 points higher than Wisconsin’s; and North Carolina’s was 12.1 points higher than South Carolina’s.³⁸

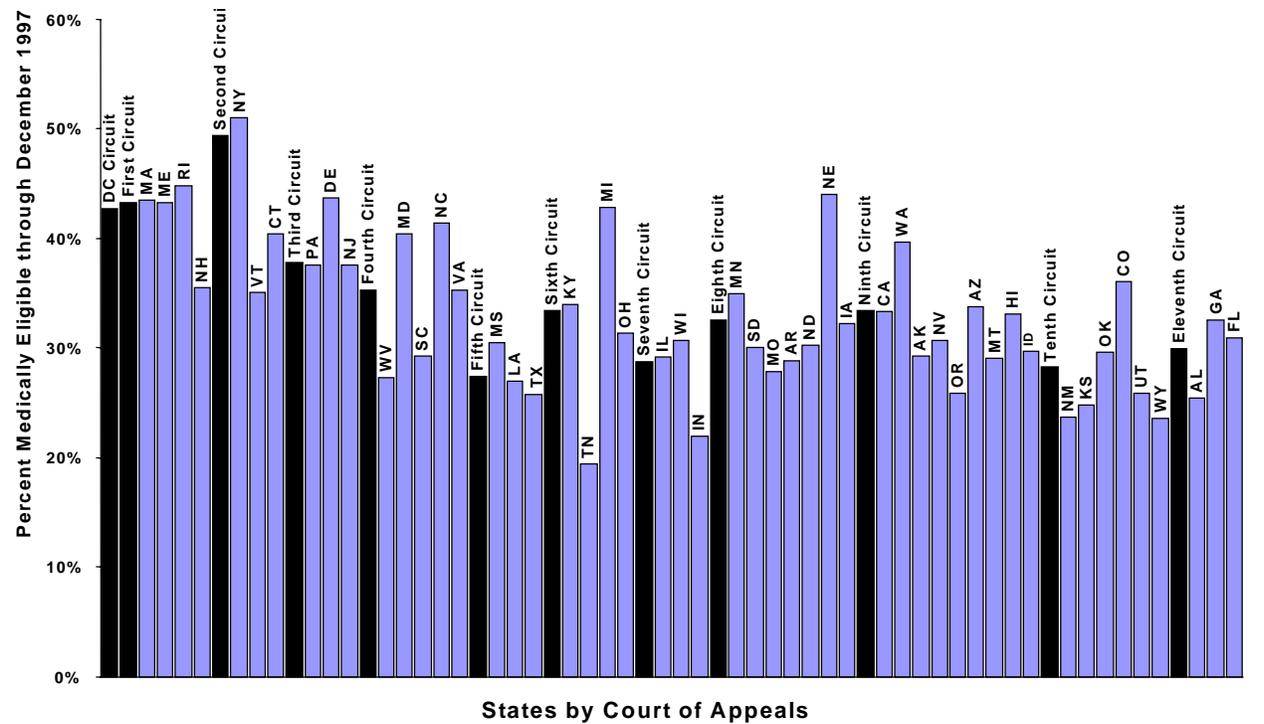
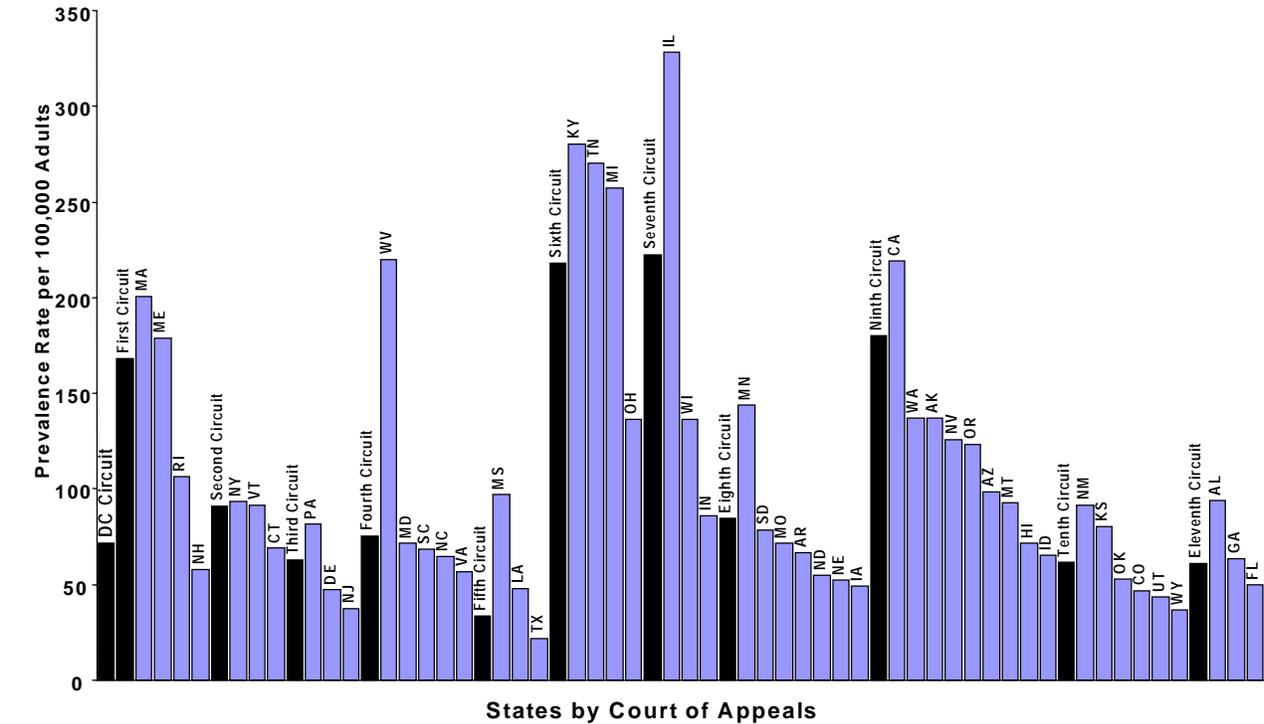
³⁷ See Exhibit App.I.9.

³⁸ Upon examination of medical eligibility figures for June 1996 in an earlier draft of this report, we suspected that these sharp differences might have reflected claims processing differences, that would even out as more cases completed the potentially long reapplication or new application processes. With an almost negligible number of reapplications pending in December 1996, however, it now appears that these disparities are the product of many other factors, including the share who filed appeals; at the present time, we do not have any information to explain these disparities.

We examined the cross-state relationship between December 1997 medical eligibility rates and March 1996 participation rates because cross-state differences in various factors could potentially explain variation in both. One hypothesis is that beneficiaries in high participation rate states were less likely to have other disabilities than those in low-rate states because of higher participation by “marginal” claimants. If so, we would likely find a negative relationship between March 1996 participation and December 1997 eligibility. A competing hypothesis is that cross-state variation in prevalence reflects how aggressively adjudicators were in classifying cases as DA&A, in which case DA&A cases in high-rate states may have been more likely to have other qualifying impairments.

We did not, however, find any evidence of a relationship between the variation in medical eligibility rates across states and cross-state variation in prevalence. Similarly, although there is substantial variation in the share medically eligible across U.S. Court of Appeals circuits, we found no clear relation between that variation and variation in prevalence (**Exhibit II.10**). Information from the case studies suggests that this variation may be related to variation in support received by beneficiaries during the appeals process (Chapter III). State, advocate, and provider assistance in appeals varied widely across the states we visited. We also found that use of organizational representative payees (ORPs), encouraged by the 1994 legislation, varied substantially across states, and that at least some organizations providing this service actively assisted their clients in the appeals process. Variation in representation by attorneys may also have been a factor, but in the states we visited such representation was very rare.

Exhibit II.10: Prevalence in March 1996 and Medical Eligibility in December 1997 by State and U.S. Courts of Appeals



Source: Lewin Group analysis of SSA’s DA&A Universe File, SSR and MBR. See Exhibit App.I.9.

III. CASE STUDY FINDINGS

A. Introduction

The primary analytic objective for the case studies was to collect contextual information on the implementation of the two changes in DA&A legislation. Three-day site visits were conducted in a selected group of four states, each of which had large numbers of DA&A beneficiaries in the SSI program. Taken together, the four states visited (California, Kentucky, Michigan, and Pennsylvania) accounted for nearly forty percent of the SSI DA&A recipients in the nation at the end of 1995. The four states vary substantially in economic characteristics and key characteristics of their March 1996 DA&A caseloads, including December 1997 eligibility (**Exhibit III.1**).

Representatives of local and regional SSA offices, disability determination services (DDSs), state government agencies, referral and monitoring agencies (RMAs), representative payees, local service agencies, and others were interviewed. The informally structured interviews probed for information on a range of topics. While the discussions were tailored to the particular agency and interviewee, the general emphases were on their roles in implementing the 1994 and 1996 policy changes, and their observations of the effects of those changes on their agencies and the clients they served. For example, how active were SSA field offices (FOs) in their outreach efforts to those whose benefits were to be terminated? What role did service agencies, representative payees, and others play in encouraging or assisting with reapplications³⁹ or new applications for disability benefits? How did the termination of benefits and the closure of the RMAs affect continued participation in substance abuse treatment programs? How fully implemented were the RMA and organizational representative payee (ORP) provisions of the 1994 legislation, and what effect did they have on the DA&A population and the system as a whole? What is the likelihood of continued substance abuse treatment in the absence of SSA requirements to participate in treatment, cash benefits, and medical assistance cards? What alternative benefits and programs are available to persons with DA&A problems, and to what extent are these substitutes for the lost cash benefits and medical assistance?

The decision making process on the DA&A reapplications was similar to that used generally in making decisions relating to SSI and DI awards, but differed in some respects. Furthermore, there were procedural differences between SSI and DI DA&A cases. In effect, the DA&A process combined features of the standard initial adjudication process with some features of the

³⁹ The term “reapplication” is used throughout this document to refer to the procedure used by drug and alcohol abuse beneficiaries (DA&As) to request the continuation of their benefits on the basis of an alternate disability allegation. Some field personnel also used the term “redetermination” to describe these reapplications. As used here, the DA&A reapplication process includes all the disability determination activities that occurred within the DDS. In SSDI cases, this included the initial folder review by a claims examiner and the subsequent examination of the folder by the DDS staff medical professional or psychologist. In SSI cases the beneficiary was entitled to a second-stage case review at the DDS level if the initial recommendation was for denial. The beneficiary elected either a second stage folder review or a face-to-face hearing at the time they filed the reapplication.

Exhibit III.1: Select Characteristics of the Case Study States

Characteristic	California	Kentucky	Michigan	Pennsylvania	United States
General State Characteristics					
Rank and Percent of Population Public Aid Recipients (1994)	1 11.7%	6 9.3%	7 9.1%	17 7.2%	-- 7.7%
Rank and Percent of Population Below the Poverty Level (1994)	7 17.9%	6 18.5%	19 14.1%	24 12.5%	-- 14.5%
Rank and Personal Income Per Capita (1995)	12 \$22,035	43 \$17,305	15 \$21,898	18 \$21,645	-- \$21,188
Characteristics of DA&A Population in March 1996					
Rank, Number, and Share of All DA&A Cases	1 42,719 21.5%	8 6,769 3.4%	3 15,064 7.6%	9 5,911 3.0%	-- 198,855 100%
Rank and Rate of DA&A Beneficiaries per 100,000 Adults Aged 18-64	6 219	2 280	4 257	25 82	-- 123
Share of DA&A Beneficiaries That Were SSI Eligible	87.6%	81.4%	81.1%	81.2%	78.5%
Demographic Characteristics					
Percent Male	69.5%	79.1%	69.5%	73.7%	72.6%
Percent Aged 18-39	36.1%	45.8%	38.6%	33.5%	37.4%
Percent Aged 40-49	40.6%	32.8%	40.6%	36.8%	38.5%
Percent Non-white	47.1%	13.6%	66.3%	40.3%	46.2%
Addiction					
Alcohol	37.5%	72.7%	44.0%	54.7%	51.2%
Drugs	27.9%	11.1%	14.9%	13.5%	16.4%
Both	29.7%	6.6%	32.4%	22.7%	26.8%
Unknown	4.9%	9.6%	8.7%	9.0%	5.7%
Length of Time on SSI and/or DI					
Less than two years	29.3%	63.4%	39.8%	37.0%	40.3%
Mean	4.4	2.9	3.6	4.3	4.0
Decision Level for SSI Beneficiaries					
Initial award	55.4%	56.8%	68.5%	40.2%	53.1%
Hearing or Appeals Council	24.0%	32.8%	17.1%	50.6%	32.4%
Percent of DA&A Beneficiaries Medically Eligible in December 1997					
Rank and Percent Medically Eligible	22 33.3%	20 34.0%	7 42.8%	13 37.6%	34.0%
SSI	34.7%	35.6%	45.3%	39.4%	35.5%
DI-only	24.2%	27.0%	32.1%	29.8%	28.6%

Sources: Lewin Group analysis of SSA's DA&A Universe File, SSR, and MBR. See Exhibits App.I.14 and App.I.15.

Our intent has been to discriminate between DA&A appeals that meet this definition and second-level appeals to the Office of Hearings and Appeals. We've endeavored to be consistent in this usage and to always refer to the second-level appeals as "appeals to the Office of Hearings and Appeals," or as "appeals to the ALJ stage."

continuing disability review process. As in other cases, the DA&A reapplication cases began with a review of the paper record by an adjudicator. This was, as usual, followed by a review by a suitable medical professional. In the SSI DA&A cases, denials by the adjudicator, with concurrence by the medical professional, were followed by an additional step. The appellant could elect to have either a face-to-face hearing with a DDS hearing examiner or a second-stage review of the record. An SSI appellant who wished to have a face-to-face hearing had to check the appropriate box on the appeals form. DI beneficiaries did not have the option of face-to-face hearings or a second stage record review at the DDS stage.

In summary, the goals of the case studies were to:

- provide preliminary indicators of answers to basic research questions;
- identify state and local governmental policies likely to affect the results of the change in federal policy;
- identify likely effects on operations of treatment and other DA&A service agency operations;
- assess possible reasons for client decisions regarding reapplications or new applications, and external influences on those decisions;
- inform the development of the econometric models; and,
- provide suggestive information on the effects of the policy change on the lives of former beneficiaries.

The reader is cautioned that there are a substantial number of ways in which the case management and processing procedures employed in the DA&A context differed from those typically used for other SSI and SSDI populations. For this reason, generalizations from this context to broader management and processing issues may be very misleading.

In **Section III.B** we provide a synthesis of the most interesting findings from the case studies. In **Section III.C** we highlight some issues that arose during the case studies that seem to be deserving of further study in the context of the broader research effort. A detailed discussion of the case study methodology appears in the **Appendix**.

B. Findings

1. Introduction

The purpose of this section is to provide a synthesis of the key observations and findings from the case studies. The structure roughly follows the implementation process of the SSI/DI policy changes, beginning with information relevant to the 1994 policy changes, followed by information concerning the 1996 changes.

2. The Referral and Monitoring Agency Process

The 1994 legislation established a nationwide system of referral and monitoring agencies (RMAs) to work with the DA&A population. Prior to the passage of this legislation, smaller, less comprehensive RMA programs had existed in a number of states, including three of the four states visited. The post-1994 RMAs operated under contract to SSA, and were charged with conducting an initial evaluation of DA&A beneficiaries, referring them to appropriate treatment services, then gathering monitoring data from the treatment agencies to assure that the clients were participating and benefiting from the treatment services. Failure to comply with the mandated treatment program was grounds for suspension of SSI/DI benefits, and repeated failures could lead to termination of benefits.

Establishing the RMA program was a major undertaking for SSA and its contractors, and there was simply not enough time between its initiation and its termination to fully implement the program and perfect the procedures. SSA approved the general assessment and intervention protocols, and provided address information to the RMA contractors to enable them to contact DA&A beneficiaries. One corporation, Maximus, Inc., held the contract for most (43) states, but there were a few states, including Michigan, where alternate arrangements were made to provide the RMA function. In most cases, the actual day-to-day staffing and operation of the RMA was subcontracted to local agencies. Consequently, the pace of implementation varied widely across states and localities, and in some cases the programs had barely been started by the time the 1996 legislation was passed and their role was eliminated. While virtually none of the persons interviewed felt that the RMA effort had been fully successful, there were a number of staff members within SSA, ORPs, and local RMA contractors who found merit in the concept and felt that some individuals had been helped by the referral and monitoring activity.

Principally due to the brief time period available for implementation, a variety of logistical and communications problems characterized the RMA process in each of the four states we visited. One logistical problem mentioned in every state was that many of the addresses of the beneficiaries that SSA provided to the RMAs were apparently inaccurate. Repeatedly, we heard that the RMAs had difficulty contacting individual beneficiaries, and that many benefit suspensions were initiated due to these contact failures. The high mobility of these recipients apparently led to frequent changes in address that weren't always reported or reflected in the SSA CO databases on a timely basis. In cases where the monthly benefit was deposited directly into a bank account, it was also possible for incorrect addresses for representative payees to remain on record for some time. It appeared that there were cases in which the RMA simply did not receive the most current address information.

As might be expected given the magnitude of the procedural changes and the limited time to implement them, there appear to have been some problems in communications between the RMAs and the SSA field offices. RMA staff complained that they would send the field offices suspension or termination notices, only to find out that the field office had continued the recipient's benefits. Field office staff told us that they were concerned about inadequate due process in the RMA suspension and termination procedures, and questioned the accuracy of the information in the RMAs' reports. Field office staff often felt compelled to independently verify reports of treatment non-compliance with the beneficiary or the treatment provider. Also, some beneficiaries apparently became compliant in the face of threatened suspensions.

Some provider staff suspected that the field office personnel were too trusting of claims made by substance abusing beneficiaries. They argued that FO staff members who had no experience working with drug addicts and alcoholics might be more inclined to give the beneficiary the benefit of the doubt, accept their excuses or protestations of innocence as true, and continue benefits. Conversely, those with prior personal experience with this population might treat the same stories with skepticism.

Because of the delays in implementation of the RMA program in some areas, a good deal of the RMA benefit suspension activity actually occurred after the announcement that all benefits would be terminated due to the 1996 policy changes. The suspension process could be time consuming for the FO staff, and it was not uncommon for there to be repeated instances of benefit suspension and reinstatement. Some SSA field office staff indicated that they placed a low priority on processing benefit suspensions for beneficiaries whose benefits were to be terminated in a matter of months anyway.

While the 1994 legislation mandated treatment participation, it included no targeted funding for the delivery of substance abuse treatment. The RMA would assess the client and refer them to an appropriate treatment provider. However, the provider remained dependent on their regular funding sources—typically a combination of state and Federal Substance Abuse Prevention and Treatment Block Grant funds—to cover the cost of providing that treatment. While availability of treatment capacity doesn't appear to have been a widespread problem, there were situations in which adequate substance abuse treatment capacity was not readily available, resulting in some beneficiaries being placed on long waiting lists and not receiving prompt treatment. The frequency of this problem varied across localities, and depended on the treatment population (e.g., methadone vs. alcohol, men vs. women). Treatment providers were also asked to provide regular reports to the RMA on the client's participation in treatment and to report breaches in abstinence. While most providers complied with these requirements, accounts from SSA, RMA, and treatment provider staff indicated that these reports were not always provided as requested.

In summary, the nationwide system of RMAs called for by the 1994 legislation was barely established and operational before the 1996 legislation was passed and the agencies were notified that they would be ceasing operations. Establishing these agencies was a complex undertaking, and there simply was too little time between their development and their termination to provide a good test of their utility. Several observers from a range of perspectives felt the process was promising, and cited anecdotal accounts of its effectiveness, while others were more skeptical. It appears that a substantial number of non-compliant beneficiaries were dropped from the rolls due to the RMA activity, and, further, that some number of beneficiaries did, in fact, benefit from the mandated treatment participation. Conversely, the RMA process was an expensive undertaking that may or may not have proved cost effective were implementation more complete.

3. *Organizational Representative Payees*

The 1994 legislation stated a preference for the use of organizational representative payees (ORPs) for clients with DA&A problems. Several of the ORPs we interviewed appear to have played a significant role in providing information and support to clients. Both ORP and SSA staff interviewees reported that the protective way some ORPs managed beneficiaries funds appears to have significantly contributed to enhancing the beneficiaries quality of life, and even

lessening the frequency or severity of substance abuse. Some of the ORPs also appear to have played an important role in assisting their clients with filing reapplications to the benefit termination following passage of the 1996 legislation, though others played little or no role in that process.

It is noteworthy that the use of ORPs seems to have varied widely across regions; there were areas in which ORPs were almost unheard of, and others where their use seemed quite widespread. Some SSA FOs and regional offices appear to have been more successful in their efforts to recruit and employ ORPs than were others. FO staff in areas that were successful reported that they felt the DA&A program worked much better, in general, and that their previously frequent problems in managing the representative payee program decreased substantially. Areas that were not successful in recruiting many ORPs reported continued high rates of problems with the representative payee process. In the areas that reported low usage of ORPs, family members, friends, and acquaintances of the beneficiary, some of whom were substance abusers themselves, were the most common payees reported. SSA FO staff reported frequent changing of payees, allegations of misuse of funds, and observations that much of the benefit amount went for the purchase of drugs or alcohol.

While we cannot assess how typical they were, several of the ORPs we interviewed reported having established highly structured, accountable systems for managing beneficiaries funds. Routinely, rent and utility bills were paid directly by these ORPs, and only small weekly amounts of cash were provided to the beneficiary. Some of the ORPs made arrangements with grocers, clothiers, and other merchants to accept individualized gift certificates, which the beneficiary would have to present along with identification. The point of these efforts was to ensure that the funds were used to obtain needed articles rather than substances to be abused. One ORP reported that they regularly made child support payments in compliance with court orders, and that they were successful in setting up savings accounts for some beneficiaries who had received lump-sum payments. The same agency also required sobriety checks before they would dispense the weekly cash allotment. These practices were not universal, and were sometimes highly controversial in their communities, but were believed by the agency in question to have had a salutary effect on the beneficiaries' functioning and quality of life.

ORPs differed in how they were compensated for providing the funds management and other supportive services. During the period between implementation of the 1994 law and the 1996 changes, SSA allowed the ORPs to retain a monthly management fee of up to fifty dollars. Some used these fees to hire staff members to manage the program. Some of the other ORPs we interviewed were already publicly or charitably funded, and provided similar services but declined to accept the management fees because they lessened the funds available to their clients.

The agencies were often recruited by SSA field or regional offices, and some were even temporarily allocated office space in the SSA FO to facilitate their assumption of the representative payee responsibility for DA&A beneficiaries. Client enrollments in some cases grew to several hundred, and some ORPs had computer systems to support the funds management activities. Some employed case managers to assist their clients, and worked actively with the RMAs to ensure participation in treatment. Others were banks or other financial institutions that only managed funds and played little or no other role in their clients' lives.

Many of the ORPs appear to have ceased functioning following the implementation of the 1996 policy changes. There were several reasons for this. Many of their former clients were no longer eligible for SSI or DI benefits. The allowable management fee was reduced from fifty dollars to twenty-six dollars per month; ORPs whose staffing and operational support depended on those fees apparently could no longer balance their budgets. While this observation should be confirmed by examination of the SSA administrative data, we were told that many of the former DA&A beneficiaries who retained eligibility were no longer required to have representative payees after implementation of the 1996 legislative changes. Reportedly, some of those who did retain representative payees reverted to the use of individuals as payees.

4. Designation as a DA&A Beneficiary

The number of people who were designated as drug and alcohol abuse beneficiaries grew very rapidly over the late 1980s and early 1990s. Prior to the passage of the 1994 legislation, there were relatively few consequences associated with being designated as a DA&A beneficiary. In those states that had RMAs before 1994, the designation could result in referral to treatment. There were, however, few adverse consequences associated with the designation. With passage of the 1994 legislation, there were a number of important changes. For the first time, SSDI beneficiaries could be assigned DA&A status. RMAs were established in all states, with higher levels of funding and staffing; representative payees were required, with a preference given to ORPs; and a three-year limit was placed on eligibility for this population. With passage of the 1996 legislation, DA&A beneficiaries were no longer eligible for benefits unless they could demonstrate their eligibility on the basis of an alternate disability allegation.

The designation of a program participant as a DA&A beneficiary appears, however, to have been an inexact process. Field office staff and experienced disability law attorneys told us of cases in which persons were designated as DA&A when substance abuse may not have been their presenting problem, or even a major factor in their disabling condition. As a consequence, when the termination process was implemented following the 1996 legislation, some recipients may have received termination notices who might otherwise have been unaffected. It seems unlikely that there were a large number of such cases, nor is it clear how one could unambiguously demonstrate the frequency of the problem. This questionable designation as a DA&A beneficiary may have occurred throughout the time prior to passage of the 1996 legislation, and was attributed by interviewees to one of three factors:

1. Some attorneys were said to consider awards based on DA&A to be relatively easy to obtain, particularly in contrast to awards based on mental illnesses. One experienced attorney described DA&A awards as “a slam dunk,” because they required relatively little development of medical evidence beyond the applicant’s own account of their substance abuse history. This attorney alleged that some applicants were even “coached” to exaggerate their SA history when it may have been relatively minor or distant in time. It should be noted that some of the DDS interviewees contradicted this observation, claiming that DA&A awards were no easier to obtain than were others.
2. When following the normal process, DDS staff members must make an award in a case as soon as they determine that the applicant is eligible on some basis. When DA&A was among the allegations, then other evidence—especially more ambiguous evidence relating, for

example, to mental impairments—may not have been thoroughly explored or recorded. From a procedural perspective, this is entirely reasonable and efficient, and hastens the award of benefits. By comparison, an applicant who alleged liver disease and back pain might be approved based on liver function testing, and the evidence that could support an allegation of disability due to chronic back pain—far more difficult and time consuming to substantiate—might not be fully developed.

3. A DDS official in one state and SSA FO staff members in another state volunteered their belief that some DDS staff members showed a preference for the DA&A designation in ambiguous cases. In cases where an applicant may have had some history of substance abuse in addition to some other possible basis for a finding of disability, DDS staff may have felt that the decision to award on the basis of DA&A was in the best interest of the client. The rationale was that the DA&A status would increase the likelihood of the applicant's becoming involved in treatment, and having a representative payee to assist in funds management. An unintended side effect was that the client may have been subject to benefit termination after passage of the 1996 legislation.

It should be noted that any beneficiary who received a notice of termination of benefits due to the 1996 policy changes had a full array of procedural due process provisions available to assure continuation of benefits if that were the proper outcome. They could reapply under an alternate disability allegation and, assuming their response was sufficiently prompt, experience no interruption in benefits. The impact of these questionable designations as DA&A beneficiaries would be that they might have to pursue a reapplication process that might otherwise have been unnecessary. It may be, though, that some such individuals failed to pursue a reapplication, possibly because they were not aware that they had another disabling condition which was sufficiently severe to make them eligible.

5. Role of the SSA Field Offices in the 1996 Policy Changes

Social Security field office activities in relation to implementing the termination and reapplication process varied in both level of effort and approach. All of the FOs we spoke with undertook significant outreach activities to inform DA&A beneficiaries of the impending benefit termination, their right to reapply, and the necessary procedures. In every case, the employees we spoke with appeared to be genuinely concerned with the welfare of the affected beneficiaries. Reports from field office staff suggest these outreach efforts may have been associated with a substantial increase in the reapplication rates. One field office reported, for example, receiving reapplications from only forty percent of beneficiaries after the initial notice was distributed. After their relatively aggressive campaign to contact beneficiaries and representative payees, the reapplication rate rose to eighty percent. A confounding factor is that reapplication rates could be expected to rise over time without special interventions, and since each of the FOs we visited had engaged in additional outreach activities, we observed no control condition. Some of the actions undertaken by the FOs are described below:

- Providing briefings or training sessions to those in the community who are in positions to interact regularly with current or potential beneficiaries. These presentations typically included the changes in the law and the structure of the reapplication process. Those in attendance varied, but included attorneys, social service agencies, public health officials,

advocacy groups, units of state and local government, representative payees, and other community leaders;

- Reapplication packages were prepared and distributed to groups in the community that were in a position to contact beneficiaries and assist in preparing the paperwork and gathering medical and lay evidence in support of the reapplication. Some of the FOs routinely provided technical assistance to these groups in their efforts;
- Multiple efforts to contact the beneficiaries and inform them of the pending benefit termination and their right to reapply, by mail, telephone, and occasionally even in person. There were repeated mailings of brightly colored letters in one FO. In another, every beneficiary who had failed to respond was sent a series of letters notifying them that they were to appear at the FO on a specified date and time for a scheduled appointment. Extensive efforts were made to obtain correct addresses for beneficiaries and representative payees, and some phone contacts were made;
- Advising SSI beneficiaries who were reapplying to request a face-to-face hearing at the DDS in case of denial at the initial stage. At the time they filed the reapplication, the beneficiary had to specify their preference for either a face-to-face hearing or merely a second-stage review of the record. Interviewees reported taking this action out of their belief that the award rate is higher for those who attend a face-to-face hearing, although we have no unambiguous evidence that this observation is correct in this context. Note that face-to-face hearings at the DDS level were not an option for DI recipients, whose only recourse to a face-to-face hearing was before an administrative law judge (ALJ) with the Office of Hearings and Appeals (OHA);
- In one FO, beneficiaries who came to the SSA office to file their reapplications were scheduled for their consultative examinations (CEs) with physicians, psychiatrists, or psychologists (as appropriate) at that time, to increase the probability that they would keep the appointment. In some cases, they were able to schedule the CEs for later on the same day, and some were even located in the same building as the FO;
- It was routine practice to hold the DDS face-to-face hearings in the SSA FO, because that was a location with which the beneficiaries were already familiar. This practice had the added benefit of helping to assure the security of the hearings examiners, though security issues proved to be far less a concern in the process than was anticipated; and.
- In compliance with SSA policy, the FOs interviewed were consistently “liberal” in granting findings of “good cause” for a delay in submitting a reapplication. In some cases, FOs reported finding good cause for late filing well into 1997.

6. Other Assistance With the Reapplications Process

Across the four states and multiple localities there were widely divergent patterns in the types and levels of assistance available to those facing termination of benefits. In some areas there seemed to be well orchestrated coalitions of service providers and advocates who offered every kind of help imaginable. One state had a state-wide program of full-time professional advocates

housed in local human services offices whose responsibility it was to ensure that all those eligible for benefits received them. Other governments seemed to have concentrated on efforts to assure continuing treatment availability (with varying success), while largely ignoring the benefit termination process, or to have paid little attention to the entire issue. Some groups, especially attorneys, that have traditionally been active in assisting those applying for benefits appear to have been relatively quiescent during this process.

We spoke with representatives of several groups, including some ORPs, advocacy groups, homeless coalitions, and a city health clinic, who had been very actively involved in encouraging beneficiaries to reapply, and assisting them through the process. Some groups set up reapplication “clinics” in which staff members would assist the client in completing the SSA reapplication forms, including medical records release forms. They would then send the completed package to the SSA field office for processing. They sometimes helped arrange for independent medical examinations, accompanied appellants to appointments and hearings, referred them to attorneys, and provided other supportive services. SSA field offices were instrumental in providing briefings and training on the reapplication process to many of these groups, and sometimes supplied them with packages that included all the forms needed to reapply.

There were also reports of family members assisting with the reapplication process in some cases, although we obtained little sense of how commonly this occurred or how effective the family members were. It seems unlikely that many family members would have had the knowledge of the process that many of the professionals might. There were indications that family members, along with case workers, often provided testimony at face-to-face hearings held by DDS hearings examiners.

Reports indicated that relatively few beneficiaries were represented by attorneys or other formal representatives during the reapplication process, at least through the DDS stage. There were a number of interesting points made by those involved in the process in relation to the involvement of formal representatives in the process. Most of the observations were from DDS hearings officers or SSA administrative law judges.

In general, attorney participation in the process was widely believed to significantly increase the probability of award. The stated reasons for this were that attorneys often were more successful in assembling relevant medical evidence, and in structuring the beneficiary’s presentations before the hearing examiner in such a way as to demonstrate their disabling conditions.

Attorney participation was said to be relatively infrequent in the DA&A reapplication process, reportedly due to the low likelihood of their receiving a reasonable level of compensation for their participation. An ALJ explained that attorneys rely on a fixed rate contingent fee which becomes substantial only when a prospective beneficiary has been without benefits for long enough that there is a substantial lump sum payment due. As of the date of our interviews, the period of benefit interruption had been too brief for the DA&A population to make this sum attractive. To the extent that the claim for disability is based on an allegation of a mental disorder, or other condition that is relatively difficult to substantiate, formal advocates may find it less attractive to assume the role of representative.

In one state we found non-attorney lay representatives who had somehow gained a working knowledge of the reapplication/appeals process. Some worked in conjunction with the attorneys, while others were independent operatives. Reports varied on the relative effectiveness of these lay representatives.

7. Reasons that Beneficiaries Did Not Reapply

We were told of a number of reasons that clients did not file reapplications. As discussed earlier, we did not interview individual beneficiaries. More definitive information on this subject is likely to be available from the CSAT multi-site study of the DA&A population. The information that follows comes only from the observations of staff member interviewees in the various agencies visited. We took some comfort in the relatively high level of consistency of observations across areas and agencies. A listing of some of the more common explanations follows.

- We were regularly told that many of those who did not reapply had no disability other than DA&A, and so saw a reapplication as pointless. This group was often described as being relatively young and in generally good health were it not for their substance abuse problem. Many interviewees speculated that some in this group might reapply in future years as they incurred other health problems, such as liver disease or HIV, as a consequence of their substance abuse;
- Many of the clients did not have stable addresses and may have been difficult to contact. Even when there was a stable representative payee who could be contacted, they may not always have informed the beneficiary. Some field offices reported that multiple efforts over a period of months were required to contact the beneficiaries;
- In some cases there may not have been accurate current addresses for either the beneficiary or the representative payee, especially when the monthly benefit check was deposited directly into a banking account. In such cases it is possible that neither the beneficiary nor the representative payee could be readily contacted;
- Several interviewees who had occasion for direct contact with DA&A beneficiaries reported that some beneficiaries were confused by the termination notice. Some beneficiaries thought that it was associated with the referral and monitoring agency process, and had resulted from their alleged failure to comply with treatment participation requirements. Others thought that it might have been a reminder that their benefit was limited to thirty-six months, as required by the 1994 legislation, and perhaps concluded that they had more time than the letter indicated. There were also reports of beneficiaries who simply denied that their benefits would be terminated until it actually happened;
- We heard repeatedly that, “Those most in need of the benefit are also those least able to complete the reapplication (or initial application) process.” These clients were often described as having low functional ability and limited capacity to comply with the requirements of the relatively complex and time consuming reapplication process. For persons fitting this description, whether or not they reapplied may have depended almost

wholly on whether there were a willing and knowledgeable individual or agency to guide and support them through the process; and

- We heard occasional anecdotal reports of clients who returned to work upon receipt of the notice of termination. In some cases, they were said to have responded positively to the mandatory treatment requirements associated with the 1994 legislation. Some of these clients had reduced or eliminated their substance abuse and were returning to a level of functioning consistent with employability. Some of these beneficiaries simply took the occasion of the termination notice as an opportune time to become independent and self-supporting. Nearly every interviewee indicated their belief that these cases were relatively rare.

8. The Role of Consultative Examinations (CEs) in the Process

Consultative examinations (CEs) are medical, psychiatric, or psychological examinations provided by professionals under contract with the state disability determination service. They are obtained to supplement or complement medical evidence of record (MER) obtained from other treatment providers, such as the professionals who provide routine care to an applicant or appellant. DDS staff members described these examinations as helpful in their decision making process, but both DDS staff and others involved in the process complained that CEs were a poor substitute for a well developed treatment history. During the termination process, CEs were often necessary due to the limited availability of current or historical evidence of medical or psychiatric treatment.

Some advocates strongly complained that the CEs were often too brief and perfunctory, and that some of the examiners were biased against those with substance abuse disorders. In some areas, substantial efforts were made to obtain appointments with other medical, psychiatric, or psychological professionals whom those advocates believed would conduct a more thorough and/or less biased examination of the beneficiary.

SSA and DDS staff disputed the advocates' charges that the CEs were biased or of poor quality. They pointed to the Professional Relations staff function at the DDS that provides orientation to new consultative examiners, investigates all complaints, makes unannounced site visit inspections to CE offices, monitors the duration of time between CE appointments, and conducts limited numbers of client satisfaction surveys on the CE process.

Almost without exception, DDS staff reported that the scarcity of well developed historical records on medical conditions and their treatment limited their ability to make well informed decisions on continuing eligibility. Especially in the case of mental disorders, a history of the beneficiary's functioning and treatment over a period of months or years is considered very helpful to making a clear determination. All parties agreed that CEs were a weak substitute for such a history. Significant efforts were often made to obtain historical MER, but sometimes with limited success. In a substantial number of cases, the CE was the only medical evidence available, especially at the initial review stage.

Where it was available, lay evidence of functioning was provided by family members, representative payees, case workers, and other knowledgeable persons. All parties seemed to agree that such evidence was helpful in evaluating a beneficiary's allegations.

9. The Role of State Disability Determination Services in the Redetermination Process

Operating under agreement with the SSA, it is the routine responsibility of the state disability determination services (DDSs) to evaluate whether an applicant's disability is such that they are eligible for Social Security disability programs. Normally, the thoroughly trained adjudicators employed by the DDS review the applications and medical records of applicants and make a recommendation for approval or denial of benefits. In all cases, the initial decisions made by these adjudicators are subsequently reviewed by qualified medical professionals employed by, or under contract to, the DDS. If the adjudicator and the medical professional agree that award of benefits is appropriate, the decision is typically final.

These agencies also conduct continuing disability reviews (CDRs) for a small sample of current beneficiaries, on an ongoing basis. A small cadre of specially trained hearing examiners typically conduct face-to-face hearings as part of the CDR process. Usually, these are staff members who were first trained as adjudicators, then received additional training in the hearings process. All other determinations are based solely on the review of the record. All decisions can, of course, be appealed to the SSA Office of Hearings and Appeals where face-to-face hearings can be held by administrative law judges. There are further due process stages, eventually including the court system.

The decision making process on the DA&A reapplications was similar to that used generally in making decisions relating to SSI and DI awards, but differed in some respects. Furthermore, there were procedural differences between SSI and DI DA&A cases. In effect, the DA&A process combined features of the standard initial adjudication process with some features of the continuing disability review process. As in other cases, the DA&A reapplication cases began with a review of the paper record by an adjudicator. This was, as usual, followed by a review by a suitable medical professional. In the SSI DA&A cases, denials by the adjudicator, with concurrence by the medical professional, were followed by an additional step. The appellant could elect to have either a face-to-face hearing with a DDS hearing examiner or a second-stage review of the record. An SSI appellant who wished to have a face-to-face hearing had to check the appropriate box on the reapplication form. DI beneficiaries did not have the option of face-to-face hearings or a second stage record review at the DDS stage.

The relatively large number of SSI appellants who requested face-to-face hearings—and the short time in which all these cases had to be processed—imposed a substantial workload burden on the hearing examiner staff. In order to handle the volume, some DDSs had to train a number of additional hearing examiners to deal with these cases. For example, one state that normally had four hearing examiners, trained an additional twenty adjudicators for these responsibilities, raising the total number of hearing examiners to twenty-four. At the conclusion of this process, the temporary hearing examiners returned to their duties as adjudicators or other roles on the DDS staff.

In every state visited, we were impressed with the knowledge and professionalism of the DDS staff members we interviewed. There were features of the reapplication process, however, that made the determinations of whether an appellant met the criteria for continued participation in the program difficult.

A key issue in the eligibility determination process is the interpretation of the materiality of the DA&A condition. The standard seems relatively clear in principle, but may have been difficult to communicate and apply in practice. Conversations with some hearings examiners left some doubt in our minds that the actual practice always conformed to the intent. Stated in simplified fashion, and to the best of our understanding, the decision rules were intended to be as follows.

1. Is the person too disabled to work?
2. If “No” to Question 1, deny benefits.
3. If “Yes” to Question 1, would the person remain disabled if they were to cease substance abuse? Clearly, if the appellant were no longer abusing substances and remained too disabled to work, this question was not relevant. However, if there were evidence of continued substance abuse, then the decision became more difficult. Evidence of their functioning during periods of sobriety (e.g., jail stay, treatment program stay, etc.) could be very helpful in answering this question, but it was often not available. This could become a “thought experiment” in which the evaluator must assess the probable level of functioning of the person in the hypothetical absence of the substance abuse behavior.
4. If the answer to Question 3 is “Yes,” then award the benefit—DA&A is not material.
5. If the answer to Question 3 is “Cannot ascertain,” then award the benefit. Decide in favor of award if the evidence is too ambiguous to interpret definitively.
6. If the answer to Question 3 is “No,” deny the benefit—DA&A is material.

The DDS hearing examiners we interviewed reported that some types of disability allegations are significantly more difficult to evaluate than are others. Using an example of a physical illness, allegations associated with chronic back pain typically lack the sort of clear cut evidence that is found in other illnesses. In the case of liver disease, by contrast, there are critical values on specific laboratory tests that may define a specific SSA disability listing. Mental health disorders were almost universally reported to be in the group of disability allegations that are often more challenging to evaluate. The hearings examiners felt that assessment of mental disorder allegations required significantly more judgment on their part than most cases they are called on to evaluate. When a long term treatment history is not available, as was often the case for DA&A reapplications, their judgment was especially difficult. This observation is relevant in light of the substantial number of DA&A reapplications where the alternate disability allegation was of a mental disorder.

A number of hearing examiners we interviewed volunteered their assessments of the veracity of appellants’ statements during the hearing process. In general, their assessment was that most appellants responded honestly to most of the questions they were asked. Interviewees did note a couple of exceptions to this general observation. They thought that the DA&A beneficiaries had

“gotten the word” that they were to de-emphasize substance abuse behavior, so the hearing examiners felt the reports of current substance abuse probably understated the true current level. The other observation was that many of those with serious mental illnesses tended to “fake good,” or appear to be more “normal” and functional than they were in fact. Other observers of the process explained this latter observation by pointing out how uncomfortable and counter intuitive it was for many people with such disorders to “argue for” their being incapable of independent functioning. The hearing examiners thought that one of the major contributions of attorneys and other informal advocates in the process was to bring out evidence of the actual extent of impairment of those with serious mental illnesses.

While we have no unambiguous basis to evaluate their claim, several of the DDS and SSA FO staff we interviewed indicated that they believed face-to-face hearings in SSI cases increased the probability of benefit award at the DDS level. Without exception, hearing examiners told us that they felt much more confident of their decision after meeting the beneficiary, and that they often interpreted the medical evidence quite differently as a consequence of their first-hand observation of the beneficiary’s behavior. From our limited observations, there appear to have been substantial variations in the proportion of cases that had face-to-face hearings across areas. In some places SSA FO staff, advocates, or others who assisted DA&A beneficiaries in the reapplication process, routinely instructed them to request a face-to-face evidentiary hearing at the DDS. Reportedly, this did not happen in other places, with the consequence that only two independent stages of folder review occurred.

One hearing examiner interviewee made an interesting observation related to the large number of new, temporary hearing examiners who were reassigned from other duties to conduct DA&A hearings. After the initial denial based on a review of the case folder, SSA procedures require that the case be reviewed by a staff physician (or a psychiatrist or psychologist in the case on an allegation of a mental disability). The suspicion is that inexperienced examiners are reluctant to challenge the opinion of the staff medical experts, while a seasoned hearing examiner is more likely to place all the evidence into the context of the client they see before them and find for award even though the staff medical opinion was in favor of denial. (Note that the case would not come to the hearing examiner unless the staff medical opinion had supported denial of benefits.) The hearing examiner’s supervisor reported noting no such difference in decisions.

10. Observations on Beneficiaries Lives After Benefit Termination

As was indicated earlier, the CSAT and PLDB studies will serve as the primary source of information about the lives of beneficiaries whose benefits were terminated. The case studies provided little clear evidence on the lives of individuals whose SSI and DI program benefits were terminated or of those who continued to receive benefits based on an alternate disability. A number of observations were made repeatedly by interviewees, but the evidence from other data sources will be important to assess their accuracy. We obtained little statistical data that supported these reports, and it would not have been possible to clearly establish a causal link had the reports been supported.

The income level of former beneficiaries and their households was widely thought to have decreased substantially. In those States that had general assistance (GA) programs (California and Pennsylvania), the level of cash payment and food stamps combined appears to have been

substantially less than the amount of the SSI/DI payments. We heard no reports of adults with children returning to the TANF programs, although this seems a likely outcome for some.

Among the substance abuse treatment staff, ORP staff, and local RMA contractors interviewed, there was virtual unanimity on the observation that former DA&A beneficiary participation in treatment programs dropped dramatically when the referral and monitoring process ended in January of 1997. While assessments of the value of the mandated participation in treatment varied, interviewees agreed that the referral and monitoring process did increase treatment participation, and that participation rates fell substantially when the requirement no longer applied. Some of the treatment programs we spoke with that had specialized in serving this population had changed their focus to serving other needy populations. Note that the reported reduction in treatment participation appeared to apply both to those dropped from the SSI/DI roles, and to those who remained on the roles on the basis of another disability.

While relatively few substance abuse treatment services are funded by Medicaid, there are typically a few specific services, such as inpatient hospital detoxification programs and some methadone maintenance programs that are reimbursed through Medicaid. The specific substance abuse treatment services funded through Medicaid vary, to some extent, across states. In one state, interviewees told us that some methadone maintenance clients at least temporarily lost that service as a consequence of losing their Medicaid cards. No information was readily available to determine how widespread this problem was.

Staff members at three different ORP agencies in two states reported that the majority of their clients had been unable to remain in their prior housing arrangements, and some were thought to have become homeless. Across all states and agencies, there were very few reports of former beneficiaries returning to employment. Staff members at four different treatment agencies, in two states, reported deaths from suicide that they believed were attributable, at least in part, to the stresses associated with termination of the SSI/DI benefits.

C. Some Issues Deserving of Further Study

The purpose of the case study component of the broader research effort is primarily exploratory. Rather than providing clear answers to the research questions, the aim has been to determine what issues and actors may be relevant and require further, more systematic study, and to provide a context for interpreting the quantitative findings. The following are some questions that might profitably be addressed through analysis of other data or information.

The primary criterion for the selection of the four states visited was that each had a large number of DA&A beneficiaries, with each being ranked among the top ten states. This methodology produced a good deal of valuable information about the workings of the policy change process as it applied to a large proportion of the total number of beneficiaries in the national program. However, a legitimate concern is that it may produce findings unrepresentative of those found in many states. It would be interesting to compare findings from the four states visited to some states where the number of DA&A beneficiaries was proportionately lower. What factors might account for the disproportionately low enrollments in other states, and how might conditions differ? Those factors may prove important for obtaining reasonably accurate predictions of the future size of the beneficiary population.

Interviewees concurred in their observations that the outreach efforts by SSA FOs, and assistance from state human service program staffs, service providers, advocates, and ORPs were important in determining the proportion of DA&A beneficiaries who reapplied, and thus the proportion who retained benefits under the programs. It might be worthwhile to obtain some systematic information on kinds and extent of outreach and assistance that actually took place in different areas. Such information could then be matched with the reapplication rates to quantify its importance. Continuing assistance and outreach efforts identified may be predictive of future program enrollments.

It is interesting to consider the state policy factors that relate both to high initial DA&A prevalence rates, and to high reapplication rates. To the extent that a state provides alternate income support or medical benefits, an incentive exists to shift eligible clients to other programs that are substantially or wholly funded by the Federal government (SSI, DI, Medicare, Medicaid). Two of the states visited have retained some level of state-only funded programs, and each has policies designed to assist and encourage enrollment in the Federal programs. In both California and Pennsylvania, welfare department staff seemed to have played a role in the reapplication process. In Pennsylvania, there is a State-funded advocacy program that may have been important. In both states, clients were mandated to apply for SSI as a requirement for receipt of GA benefits. There may have been some welfare staff assistance (this is unclear) in filing the application and follow through on the process.

A third state, Michigan, apparently had state-only funded programs during the years when growth in SSI peaked, and it reportedly mounted a strong effort to enroll eligibles in SSI at that time. The State has since drastically reduced the state-funded programs, and there now seems to be less of a systematic effort to promote SSI enrollment. The fourth state, Kentucky, has never had significant state-only funded benefits, nor has it ever, to our knowledge, had a policy that supported SSI enrollment. It would be interesting to attempt to gather information that could confirm these observations, and determine the extent to which such simple policy variables are predictive of SSI enrollments in other states.

Another important policy factor at the state (and national) level is the emergence of managed care programs. Every state visited either had, or was in the process of developing, some form of managed health care program(s) for their publicly funded health services. The structure of these programs varied widely, as did the methods and degree to which behavioral health services such as mental health and substance abuse treatment were to be incorporated. The implementation of these evolving efforts will almost certainly create new incentives, of differing sorts, to shift costs by including or excluding client groups like the former DA&A population. The tremendous variability in approaches will make this a complex and difficult issue to study, but it is likely to prove increasingly important as a contributor to SSA disability program enrollments over time.

Most private-practice lawyers reportedly showed little interest in assisting clients with reapplications since there was relatively little to be earned from an award. While we did not attempt it, it would be interesting to determine the impact of recent policy changes on the attractiveness of these SSI and DI cases to private attorneys. For example, we were told of measures that were intended to speed up the processing of cases through the ALJ stage (Office of Hearings and Appeals), and to increase the commonality of approaches used by DDSs and the ALJs (referred to as Process Unification Training). The apparent likely effect of these changes is

to lessen the time until a final determination is made on an initial application or reapplication, and to lessen the probability of the ALJ overturning the denial by the DDS. Both results would appear to lessen the expected value of an SSI or DI case to attorneys working on a contingent fee basis. The judgement of those we interviewed was that attorney involvement increased the probability of benefit award. Analysis that first tested this assertion, then projected the probable level of attorney involvement in future cases, could improve the accuracy of future caseload estimates.

It would also be interesting to look at the relationship between approval rates and the type of review process that occurred. What was the distribution of outcomes for cases that concluded at each stage in the process, from the initial record review stage, to second-stage case review or the DDS hearing examiner stage, and on through the ALJ hearing stage? While we obtained little hard evidence to support the position, there appeared to be a widespread belief among SSA FO staff, DDS hearings examiners, and external advocates that face-to-face hearings increased the probability of benefit award or continuation. To the extent that the data are obtainable, it would be informative to systematically assess the relationship between the review processes and outcomes. Such evidence, taken in the context of procedural protocols likely to be in place in the future, could further enhance the accuracy of caseload estimates.

IV. RESEARCH IMPLICATIONS

A. Additional Research Planned for the Project

Additional quantitative and qualitative research is planned on the impacts of the change in DA&A policy. This includes:

- *Analysis of the impact of the policy change on caseloads and benefits.* This will include development of counterfactual claims, allowances, and eligibility continuations through the application of econometric methods to SSA administrative data.
- *Analysis of the impact of the policy change on the lives of beneficiaries.* This analysis will, tentatively, use data from two sources on changes in beneficiary income, employment, participation in other programs, substance abuse, treatment for substance abuse and other conditions, and illegal activities. The first is the Center for Substance Abuse Treatment (CSAT) longitudinal survey of SSI-only DA&A beneficiaries, being conducted in seven sites around the country by CSAT grantees. Respondents were first interviewed near the end of 1996. Two six-month follow-up interviews have been conducted and a third is planned.⁴⁰ The second is the Pennsylvania Longitudinal Database (PLDB) on users of public mental health services in the Philadelphia area.⁴¹ In both cases, we would like to match the data to SSA administrative data.
- *Additional site visits to case study states.* We currently plan to revisit the case study states and re-interview some informants from the first site visits plus interview some newly identified respondents. We will address issues raised by the work to date, and also focus longer-term agency and organizational policy, institutional, and other responses to the policy change.

The findings presented here have substantial implications for conducting these activities. These are discussed below.

B. Program Participation and Benefit Measurement

As discussed in Chapter II, there are several ways to define program participation at a point in time; payment made, current pay status, and medical eligibility have all been used in this report. As the analysis shows, findings concerning “terminations” will depend on which measure is chosen. Further, because benefits can be re-instated retroactively, eligibility as of a specific month may be revised at a later date.

⁴⁰ Earlier analysis of SSA administrative data for the first-round respondents showed that these cases were generally quite representative of the March 1996 SSI-only DA&A cases in their sites, although not representative of the entire cohort (Lewin, 1998).

⁴¹ We have matched cases in the PLDB to March 1996 DA&A beneficiary cases and found that a very large share of the Philadelphia County DA&A cases have records in the PLDB, and that those with PLDB records are quite representative of all Philadelphia County cases.

Because payment made and current pay status in months after December 1996 may depend on the speed with which an appeal is processed, we think it would likely to be easier to explain revised current pay status as of the latest data available than it would be to explain either of the former measures. Although revised current pay status will likely be affected by delays in the processing of appeals even after decisions are final, the impacts of delays will presumably be much greater on current payment and eligibility.

Correspondingly, it will also likely be easier to model the payment amounts associated with revised current payment status than actual payments, regardless of when they are made. Nonetheless, continuation payments made from January 1997 on to beneficiaries who were not in current pay and who were not determined to be eligible at a later date need to be counted as benefit payment, because they are not likely to be recovered by SSA. We had difficulty assessing continuation payments for DI-only cases for this report related to the structure of the MBR but will attempt to resolve these difficulties going forward.

As discussed earlier, while temporary eligibility interruptions may be inconsequential from the perspective of program costs, they are not inconsequential from the perspective of beneficiaries, especially when payment is also interrupted. When examining changes in the lives of beneficiaries, as we plan to do with the CSAT and PLDB data, it will be important to know the beneficiary's current eligibility and payment history, and not just revised eligibility.

C. Future Re-entry

One of the most problematic aspects of the proposed analysis is predicting future re-entry by those whose benefits were terminated. The findings presented, however, suggest that re-entry will be very limited, at least for the immediate future, although an economic downturn might change that. The findings make re-entry less of an immediate concern.

D. Beneficiary Classification and Characteristics

As is evident from the analysis presented in this report, we have more information on the 79 percent of DA&A beneficiaries who were SSI recipients than we do on the 21 percent who were DI-only. Background data on the 10 percent who are Never SSI, just under half of the DI-only cases, are particularly limited because, unlike the Serial cases, these cases do not have a record in the SSR. It will clearly be very problematic to develop models for all beneficiaries combined using the administrative data. The most practical strategy may be to focus on SSI recipients, augmented by separate analysis of DI-only cases, rather than to restrict the joint analyses by the limitations of the DI-only data. It may be possible to include the Serial cases with the other SSI cases, which would leave only 10 percent of the cases out of the main analysis.

Variation over time, across states, and across programs in the use of the DA&A designation, and related variation in the use of primary impairment classifications, make use of these characteristics problematic in any analysis. Developing methodologies that minimize reliance on these variables is important. For the SSI cases, the variable for addiction type may be a more reasonable candidate for modeling purposes. The permanent disability indicator may also be reliable for SSI cases.

We have previously considered focusing on non-DA&A recipients with psychiatric disorders as control cases. On the one hand, the finding that 75 percent of SSI DA&A cases were in the psychiatric category in March 1996 -- 92 percent of those with data -- seems to support that view. On the other hand, the above concerns about variability in the application of impairment codes, missing impairment codes for 19 percent of SSI cases and all DI cases, and the finding that 42 percent of those SSI recipients in the March 1996 DA&A cohort who were medically eligible in December 1997 were classified in non-psychiatric categories, suggest that broader groups should be considered.

We found that 86 percent of SSI cases and 78 percent of DI-only cases had been receiving benefits for less than six years; i.e., they were allowed in 1990 or later. This fact does not mean, however, that those who obtain benefits are very likely to exit within six years; rather, it reflects the large growth in DA&A allowances after 1988. We will still need to study exits among cases of long duration to evaluate long-term impacts on the programs. Also, in assessing such estimates we will need to keep in mind that those who entered the programs far enough in the past to have had long participation spells may be quite different than those who entered the programs more recently.

E. State Variation in Prevalence and Continuation of Benefits

Variation across states in both participation rates in March 1996 and medical eligibility in December 1997 is intriguing, and not readily explained. In modeling both terminations and allowances, state-level factors that can be measured could be predictive of these differences. Measurable possibilities include the availability and value of alternative cash benefits (general assistance and, for some, AFDC/TANF), availability of medical assistance for those not eligible for SSI or DI, the Court of Appeals circuit, and the economy. Others, such as the status of RMA implementation, field office outreach activities, and state, advocate, provider and other assistance to beneficiaries in the appeals process are not readily measurable. Controlling for unobserved state factors, through “fixed effects” specifications, may also have an important impact on the findings from any multivariate analysis.

While we had planned to conduct follow-up visits to the same case study states, it may be more valuable to visit some low-participation states; all of the states we selected were, by design, high-participation states. Medical eligibility at a later date (e.g., December 1997) might also be a criterion for selecting follow-up states. The wide-variation across states in participation rates in medical eligibility of former DA&A cases is an interesting phenomenon that is not well understood.

The introduction of managed care in State medical assistance programs was an important theme raised by many case study interviewees. In the follow-up case studies, we may want to pursue this theme further, trying to better understand how the introduction of managed care may have affected program participation of substance abusers, and their more general behavior and well-being. It would be desirable to know the extent to which changes in the lives of beneficiaries reflect state-initiated changes in the provision of medical assistance rather than SSA policy changes. It may also be important to include state indicators for the introduction of Medicaid managed care and managed behavioral care in the caseload analysis.

F. Administrative Issues

Some case study interviewees indicated that SSI recipients who elected face-to-face interviews after initial denial of their reapplication were more likely than those not electing this option to have succeeded on appeal. We are uncertain about whether we can identify those who elected face-to-face interviews in SSA administrative data, but it appears that we may. If so, we could test this claim in the context of our continuation models. We are concerned, however, about selection effects – those most likely to have a strong case may have been most likely to elect this option.

While some informants indicated that lawyers had little incentive to represent DA&A beneficiaries in their appeals, we are not aware of any careful analysis of this subject. It might be useful to analyze these incentives so as to better understand the impact of legal representation on the claims process.

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